DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

IMPORTANT NOTICE - PLEASE READ CAREFULLY

June 5, 2012

Sally Jeffcoat, President and CEO St. Alphonsus Regional Medical Center 1055 North Curtis Road Boise, ID 83706

CMS Certification Number: 13-0007

Re: Complaint survey 05/01/2012 and CoPs not met

Deemed status removed and placed under State survey jurisdiction

Full health and life safety code survey to be conducted

Dear Ms. Jeffcoat:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on May 1, 2012. Based on a review of the deficiencies identified during this investigation, we have determined that St. Alphonsus Regional Medical Center is not in substantial compliance with the following Medicare hospital Conditions of Participation (CoP):

- 42 CFR § 482.13 Patient Rights,
- 42 CFR § 482.24 Medical Record Services, and
- 42 CFR § 482.43 Discharge Planning.

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the May 1, 2012, complaint survey findings, we are required following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of St. Alphonsus Regional Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement
 actions into its Quality Assessment and Performance Improvement (QAPI) program,
 addressing improvements in its systems in order to prevent the likelihood of the deficient
 practice reoccurring. The plan must include the monitoring and tracking procedures to
 ensure the plan of correction is effective and that specific deficiencies cited remain corrected
 and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification Attention: Kate Mitchell 2201 Sixth Avenue, RX-48 Seattle, WA 98121 Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that St. Alphonsus Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When St. Alphonsus Regional Medical Center has been found to meet <u>all</u> the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Page 3 – Ms. Jeffcoat

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432 or e-mail Catherine.mitchell@cms.hhs.gov.

Sincerely,

Late Mitchell

So Jerilyn McClain, RN, MPH

Jerilyn McClain, RN, MPH
Survey, Certification and Enforcement Branch Manager

Enclosure

cc: Idaho Bureau of Facility Standards

The Joint Commission





DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

June 5, 2012

RICHARD M. ARMSTRONG - Director

Sally Jeffcoat, Administrator St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, ID 83706

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Ms. Jeffcoat:

This is to advise you of the findings of the complaint survey at St Alphonsus Regional Medical Center, which was concluded on May 1, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by

Sally Jeffcoat, Administrator June 5, 2012 Page 2 of 2

June 18, 2012, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

GARY GUILES

Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/srm Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

July 6, 2012

Aline Lee, RN Director of Patient Safety and Regulatory Compliance St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, ID 83704

CMS Certification Number: 13-0007

Re: Plan of correction received

Dear Ms. Lee:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of St Alphonsus Regional Medical Center's voluntarily-submitted plan of correction in response to the complaint survey completed May 1, 2012, by the Idaho Bureau of Facility Standards (State survey agency). I understand that the State survey agency also contacted you and provided informal feedback on the plan of correction. As per our June 5, 2012 letter, an unannounced full health and life safety code survey will be conducted by the Idaho Bureau of Facility Standards.

If you have any questions, please contact me at (206) 615-2432 or by e-mail catherine.mitchell@cms.hhs.gov.

Sincerely,

Kate Mitchell, RN, Health Insurance Specialist Survey, Certification and Enforcement Branch

cc: Idaho Bureau of Facility Standards

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 06/04/2012 1 APPROVED): 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/01/2012	
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A 000	INITIAL COMMENTS		А	000	Please see		
	complaint investigation	ncies were cited during the on survey of your hospital. cting the investigation were:		Please see enclosed pla correction		70	
	Gary Guiles RN, HFS Rebecca Lara RN, B/				correction.		
	The following acronyr	ms were used in this report:					
	ADLs = Activities of D	Daily Living					

FACILITY STANDARD

JITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

MED MGMT = Medication Management

ALF = Assisted Living Facility

CHF = congestive heart failure CRM = Clinical Resource Manager

DPSRC = Director of Patient Safety and

DTs = Delirium Tremens, a severe form of

alcohol withdrawal that involves sudden and severe mental or nervous system changes

Appt = appointment

Regulatory Compliance

ER = Emergency Room Eval = Evaluation

IM = Intramuscular 1&O = Intake and Output

IV = Intravenous

MD = Medical Doctor

ED = Emergency Department EMR = Electronic Medical Record

H&P = "History and Physical" ICU = Intensive Care Unit IDCP = Interdisciplinary Care Plan

IPOC = Interdisciplinary Plan of Care

LOC = Level of Consciousness

LIP = Licensed Independent Practitioner LMSW = Licensed Medical Social Worker

DC = discharge DC'd = Discontinued

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DA1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 000	ROM = Range of Mot RN = Registered Nur R/T = Related To VTE = venous thromo X = times	ocial Work rney Oy ccreditation Coordinator tion se pembolism (blood clot)		000			
A 115	Based on staff intervrecords and hospital grievances, it was de to protect and promot prevented the hospital grievances, comprom keep patients safe, at utilizing restraints in a Findings include: 1. Refer to A164 as if failure to ensure restrictive interve be ineffective to prote from harm. 2. Refer to A166 as if failure to ensure paties.	not met as evidenced by: iews and review of medical policies and review of termined the hospital failed te patients' rights. This al from processing all hised the hospital's ability to and prevented staff from	A	115			

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 130007 05/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTER **BOISE, ID 83706** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 115 | Continued From page 2 A 115 3. Refer to A168 as it relates to the facility's failure to ensure restraints were used only in accordance with the order of a physician or LIP and LIPs ordering restraints were authorized to do so by hospital policy in accordance with State law. 4. Refer to A174 as it relates to the facility's failure to ensure restraints were discontinued at the earliest possible time. 5. Refer to A185 as it relates to the facility's failure to ensure documentation in patients' medical records contained a detailed description of the patient's behavior during the time of restraints and patients' response to interventions used. 6. Refer to A187 as it relates to the facility's failure to ensure documentation of patients' conditions or symptoms that warranted the use of restraints. 7. Refer to A188 as it relates to the facility's failure to ensure patients' response to the intervention used, including the rationale for continued use of the intervention (restraints) was documented. The cumulative effect of these negative systemic practices resulted in the inability of the hospital to promote and protect the rights of patients. A 164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT A 164 OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 164	a staff member, or other This STANDARD is represented and hospital failed to effect the hospital failed the hospital	not met as evidenced by: iew and review of medical policies, it was determined ensure 4 of 6 patients (# 1, were physically restrained, after a comprehensive ormed and less restrictive itermined to be ineffective, betential for unnecessary use is include: al record documented a 47 ited to the facility on 1/30/12 itus and alcohol it #1 presented to the ED on She was transferred to an me after 1:59 PM as an rogress Note" documented ithat time. The medical flicting information as to as discharged on 2/09/12 or vas restrained without clear ive alternatives had been to be ineffective. Examples In Progress Note," written by in 1/30/12, stated Patient #1 bey due to multiple attempts pulling on lines." (Posey is is numerous types of soft The types of restraint(s)	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 164	the ED. The "Direct Charting 3:35 PM, called for a Assessment" to be conthet time Patient #1 and The time of arrival was Restraints were not assessment. The first physician ord 1/30/12 at 5:12 PM. rails up on Patient #1 restraints. The order Increased observation not state what "Increased observation of the time of restraints. Following the "Emerginated above, the first mentioned Patient #1 "Restraint Non-Violer 6:00 PM (entered at 6 Patient #1 had bilater and all side rails were "Alternatives to restra Covered exposed line environmental stimuli The note did not state applied in the ED or ont describe Patient # and why it was ineffer the alarm, the alarm activated and/or hear describe what the terminative to the terminative to restrain the alarm, the alarm activated and/or hear describe what the terminative to the terminative to restrain the alarm, the alarm activated and/or hear describe what the terminative to the terminative to restrain the alarm and the alarm, the alarm activated and/or hear describe what the terminative to the termina	Flowsheet," dated 1/30/12 at nursing "Adult Admission ompleted. This was likely trived on the inpatient unit. It as not documented. In the order was for 4 side to be and bilateral wrist stated "Alternatives tried: In." The documentation did ased observation" meant or intions attempted prior to the straints was a nursing documentation that the restraints was a nursing at Form" dated 1/30/12 at 6:55 PM). The note stated all wrist restraints applied a up. The note documented and stream the stream that the process of the service of the bed alarm was on the inpatient unit. It did \$1's response to the alarm ctive (e.g. Patient #1 ignored)	A 1	64			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 164	Patient #1's response whether they were us were used simultaned. An assessment which restrictive alternatives ineffective prior to the and posey restraints. 2/07/12: A physician order for #1 was dated 2/07/12 "Alternatives tried: B the response to the bineffective. A subsequent nursing Form," completed at a vest restraint was a nursing note stated F "Unable to follow inst discontinue equipme #1 was "Unable to munassisted and refus assistance." The not Restraints Attempted environmental stimul Re-oriented." The "Fidid not state what spwas attempting to pre "Decreased environm "Increased observation documentation did not had been used simulalone. The corresponding or the simulation of the corresponding or the simulation. The corresponding or the simulation. The corresponding or the simulation of the corresponding or the simulation of the corresponding or the simulation. The corresponding or the simulation of th	n" meant. Additionally, a to the interventions and sed alone or if one or more pusly was not documented. In demonstrated less as were tried and were a use of the side rails, wrist, was not documented. In a vest restraint for Patient at 2:42 AM. It stated alarm." It did not state and alarm or how it was If a vest restraint Non-Violent at 4:00 AM on 2/07/12, stated and alarm and attempts to a ructions and attempts to ant." It also indicated Patient antain balance/ambulate antain balance/ambulate as stated "Alternatives to be stated "Alternatives to be setraint Non-Violent Form" accific behaviors the restraint avent. The terms	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 164	bed alarm was the on the order. The RAC, interviewed 12:30 PM, confirmed Patient #1. She state measures and their redocumented. The hospital did not dless restrictive measures utilizing restraints for 2. Patient #3's medicayear old male who was on 3/12/12 and was of 4/30/12. The "ED Ph 3/12/12 at 10:12 PM, history of schizophrer admitted for combative A physician order, da called for "Restraint: ankles]." The order so 1:1 intervention." The 1:1 intervention had be restrictive intervention documented. A nursing "Restraint of 3/30/12 at 6:00 PM (3) was received), indicate restrained at that time Non-Violent Form," distated Patient #3 was note did not state when the state of the state	d on 4/24/12 beginning at the documentation for at the documentation for at the use of less restrictive esults were not clearly determine that the use of ures were ineffective prior to Patient #1. all record documented a 74 as admitted to the hospital currently a patient as of sysician Notes," dated stated Patient #3 had a nia and dementia. He was	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 164	stated "Alternatives to Alarm." Additionally, other less restrictive measures and their restrictive measures and their restrictive measures restrictive restrictiv	the note did not indicate measures attempted prior to do on 4/25/12 beginning at the documentation for the documentation for the use of less restrictive esults were not clearly determine that the use of less were ineffective prior to Patient #3. It record documented a 29 as admitted to the facility 26/12 with primary sm with alcohol withdrawal. In 2/20/12. A physician's less note, dated 2/06/12 at d Patient #2 was transferred or continued treatment of alcohol withdrawal. A lare Progress' note, dated indicated Patient #2 was dical floor for continued destraint Non-Violent Form', AM documented aints Attempted - Covered The documentation did not desponse to the covering of es. No other less restrictive	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 164	A physician's order, dinitiated soft restraints ankles. The order do tried: Covered exposs alternative to restraint not state what "cover meant or state why the unsuccessful. No oth alternatives were documented. A physician's order, dicalled for a restraint version as an aresponse to 1:1 intervention as an aresponse to 1:1 intervention as an aresponse to 1:1 intervention as an alternative to Photodocumented. The nursing "Restrain 2/14/12 at 12:00 PM, as an alternative to Photodocument Patient alarm or other less reattempted. The RAC, interviewed 8:00 AM, confirmed the second and their redocumented. The hospital did not eatternatives to restrain found to be ineffective 4. Patient #4's medicalled.	lated 2/06/12 at 5:19 AM, is to Patient #2's wrists and cumented "Alternatives and lines/tubes" as an its. The documentation did ed exposed lines/tubes" are intervention had been are less restrictive umented as having been lated 2/14/12 at 1:34 PM, west and soft restraints to did ankles. The order attives Tried: 1:1 alternative to restraints. The vention as an alternative was latent #2's restraints. It did its exposes to the chair strictive interventions. If on 4/26/12 beginning at the documentation for Patient is evention as restrictive essults were not clearly ensure less restrictive interventions.	A	164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TRUCTION	(X3) DATE SURVEY COMPLETED	
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A 164	the facility on 2/04/12 According to a "Histor 2/04/12 at 5:30 PM, F care related to increa There was also a doc dementia and psychological ps	and discharged on 2/08/12. Ty and Physical" dated Patient #4 was admitted for sed confusion and agitation. The sed confusion and agitation. The action of sis. The order did not sersponse to 1:1 The order did not sersponse to 1:1 The order did not include a attempted. The action of sis in the serse of sersponse to 1:1 The order did not include a attempted. The action of sersponse in the sersponse of sersponse in the sersponse of serspo	A	164			

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A 164	Patient #4. She state	the documentation for ed the use of less restrictive esults were not clearly	A	164			
A 166	alternatives to restrain	nts were consistently	A	166			
	The use of restraint o (i) in accordance with patient's plan of care.	a written modification to the					
	Based on staff interversecords and hospital the hospital failed to a restraints was incorporate for 6 of 6 patient #6), who were physic resulted in patients be and consistent directions.	not met as evidenced by: iew and review of clinical policies, it was determined ensure the use of physical prated into patients' plans of its (#1, #2, #3, #4, #5, and hally restrained. This eing restrained without clear ion to staff regarding the straints. Findings include:					
	12/06/11, stated at se updated in accordance patient following asse	int and Seclusion," dated ection III.E. "Plan of care the with the needs of the essment and evaluation." ect staff as to how this					
	10:15 AM, stated interestraints, such as re every 2 hours and pro	d on 4/26/12 beginning at erventions related to leasing the patient at least oviding care, were not listed ted staff interventions were					

OLIVILIY	OT OIL WEDIONILE G	WEDICAID SERVICES				CIVID	NO. 0936-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		SURVEY
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ST ALPHO	ONSUS REGIONAL MEDI	CAL CENTER		l	055 NORTH CURTIS ROAD BOISE, ID 83706		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	- 15			TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 166	Continued From page	<u>•</u> 11	Α Α	166			
				100			
	listed in the restraint p	em. She stated POCs					
	•	ere not individualized.					
	2. Patient #2's medica	al record documented a 29					
		as admitted to the facility					
	through the ED on 2/0	. ,					
	•	sm with alcohol withdrawal.					
	_	n 2/20/12. A physician's	1				
		ss" note, dated 2/06/12 at d Patient #2 was transferred					
	,	or continued treatment of					
	symptoms related to a						
	' '	are Progress" note, dated					
		ndicated Patient #2 was	1				
	transferred to the med treatment.	dical floor for continued					
		lated 2/06/12 at 5:19 AM,					
		s to both ankles and wrists.					
		rder, dated 2/07/12 at 6:42					
	PM, called for the use						
		nd ankle restraints. Hand ed on 2/08/12 at 10:07 AM.					
	The nursing "Restrain						
	_	2 at 8:00 AM, stated Patient					
	#2 remained in 4 poin	•					
		tts applied to both hands.					
		nts were discontinued on					J
	2/16/12 at 4:00 PM a	ccording to the "Restraint					
	Non-Violent Form."						
	The "Care Plan" for P	atient #2 was initiated on					
		ed through discharge on					
		plan of care did not reflect					
	the use of restraints.						
	The RAC was intervie	ewed on 4/26/12 beginning					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		130007	A. BUILDING B. WING		1	С		
	ROVIDER OR SUPPLIER			1055	T ADDRESS, CITY, STATE, ZIP CODE 5 NORTH CURTIS ROAD SE, ID 83706	05/0	1/2012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 166	not document the classical related to the on-go restraints. The hospital did not modified to include 3. Patient #4's med year old female adn for care related to in agitation and a relation psychosis. She was a physician's order, called for the use of and ankles. Accord Non-Violent Forms, non-violent medical AM, when restraints The "Care Plan" for 2/04/12 and maintain 2/08/12. The plan of restraints. The RAC was internated the care on-going use of nor Patient #4 was physician was presented the care on-going use of nor Patient #4 was physician was presented to the care on-going use of nor Patient #4 was physician was presented to the care on-going use of nor Patient #4 was physician was presented to the care on-going use of nor Patient #4 was physician was presented to the care on-going use of nor Patient #4 was physician was ph	ensure Patient #2's POC was restraints. ical record documented an 82 mitted to the facility on 2/04/12 acreased confusion and ed history of dementia and a discharged on 2/08/12. dated 2/04/12 at 2:38 PM, soft restraints to both wrists ing to a nursing "Restraint" Patient #4 remained in restraints until 2/07/12 at 8:00	A	166				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF	
		130007	B. WIN	G		05/0	0 1/2012
	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD COISE, ID 83706	1 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 166	A/13/12. A physician's order, dinitiated the use of so wrists and ankles. Ar at 4:57 PM, and imme for soft ankle and wrist the same restraints w Vest." The nursing "F dated 4/10/12 at 1:00 restraints were discording the "Care Plan" for P 4/06/12 at 5:58 PM are discharge on 4/13/12 not reflect the use of the The RAC was intervie at 12:50 PM. She condocument the changing related to the on-going restraints. Patient #5's POC was use of physical restraints. Patient #6's medic year old woman who on 4/17/12 and remaind orthopedic/joint unit a Patient #6 was admitted to low-gradinflammatory state) and inflammatory state) and inflammatory state) and inflammatory state).	hallucinations and He was discharged on ated 4/08/12 at 4:41 PM, fit restraints to Patient #5's nother order, dated 4/08/12 ediately following the order st restraints, documented ith the addition of "Restraint: Restraint Non-Violent Form," PM, stated Patient #5's ntinued. attient #5 was initiated on and maintained through However, the care plan did restraints. ewed on 4/26/12 beginning infirmed the care plan did not and needs of the patient g use of non-violent medical a not modified to include the ints. all record documented a 57 was admitted to the hospital ned a patient on the t the time of the survey. ted for care related to mild in dysfunction syndrome)	A	166			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		130007	B. WIN	iG			C 1/2012
	OVIDER OR SUPPLIER	CAL CENTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 166	for Patient #6 on 4/19 nursing "Restraint No 4/22/12 at 12:00 AM, restraints until this time. The POC for Patient at 9:32 PM. The care reflect the use of rest of the RAC was intervied at 9:50 AM. She condocument the changing related to the on-going restraints. The hospital did not empodified to include the modified to include the form on 1/30/12 for altered detoxification. The modificting information was discharged on 2/2. The nursing "Restraint documented Patient are restraints from 1/30/12:00 PM. Patient #1's "Care Placempleted on 2/09/12 and stated they were not include the type of and goal for the use of how/when monitoring	and the care plan did not	A	166			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		130007	B. WIN	IG_		05/01) 1/2012
	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 166	"Side rails up X4 of 4' restraint. The plan di reason, goal, or moni all four side rails up of the RAC, interviewed 12:30 PM, confirmed Patient #1. The RAC address restraints. Patient #1's POC was use of restraints. 7. Patient #3's medically year old male who was on 3/12/12 and was of 4/30/12. The "ED PM, history of schizophren. Nursing "Restraint Not documented Patient #3/30/12 at 8:00 PM under the straints or provide of restraints. The RAC, interviewed 11:10 AM, confirmed Patient #3. The RAC include restraints.	y Measures," the plan listed but this was not listed as a d not reflect an assessment, toring related to the use of n Patient #1's bed. d on 4/24/12 beginning at the documentation for stated the POC did not a not modified to include the al record documented a 74 as admitted to the hospital currently a patient as of sysician Notes," dated stated Patient #3 had a nia and dementia. on-Violent Forms" #3 was restrained from ntil 4/06/12 at 8:00 AM. ans," initiated on 3/12/12 and 24/12 did not mention direction to staff in relation to d on 4/25/12 beginning at the documentation for e stated the POC did not	A	166			
A 168	Patient #3's POC to it	ensure nursing staff modified nclude restraints. T RIGHTS: RESTRAINT	Α	168			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	IG		05/01/2	
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER		CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 168	OR SECLUSION The use of restraint of accordance with the collicensed independent responsible for the call under §482.12(c) and or seclusion by hospit State law. This STANDARD is represented the second of seclusion by hospit State law. This STANDARD is represented to seclusion by hospit State law. This STANDARD is represented to second of seclusion or seclusion or seclusion or described on review of notine interview, it was determined and followed of 6 patients (#1, #2, whom restraints were patients being subject without an appropriate of the second of	r seclusion must be in order of a physician or other practitioner who is are of the patient as specified authorized to order restraint tal policy in accordance with the not met as evidenced by: nedical records and staff remined the facility failed to be swere consistently of for the use restraints for 6 #3, #4, #5, and #6) for used. This resulted in the ted to physical restraint to order. Findings include: The facility on 1/30/12, tory and Physical" dated to the facility on 1/30/12, tory and Physical" dated to substance abuse. The patient #1 was admitted to substance abuse.	A	168			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		130007	B. WIN	G		05/0	1/2012
	ROVIDER OR SUPPLIER DNSUS REGIONAL MEDI	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
A 168	6:00 PM. The form in Initiation Assessment restraints were "All sid Wrists, bilateral." A physician order for 12:44 PM on 1/30/12 first order for restraint PM. The RAC, interviewed 12:30 PM, confirmed Patient #1. The RAC applied to Patient #1 She stated an order to not documented. Restraints for Patient accordance with a phoracy of a phoracy and male who was on 3/12/12 and was of 4/30/12. The "ED Phoracy of schizophrer stated he had come for increased aggression abdomen. The note of at first but " became was trying to leave, a and chemical sedatio Progress Notes" by a Patient #3 was walking patients' rooms. He is and was placed in wind selection.	thich was dated 1/30/12 at adicated it was a "Restraint". It stated the type of de rails up, soft limb X 2, the restraints applied at was not documented. The ts was dated 1/30/12 at 5:11 do n 4/24/12 beginning at the documentation for confirmed restraints were at 12:44 PM on 1/30/12. To apply the restraints was #1 were not used in ysician order. all record documented a 74 as admitted to the hospital currently a patient as of	A	168			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WING			C 01/2012	
	ROVIDER OR SUPPLIER	CAL CENTER		STREET ADDRESS, CITY, STATE, Z 1055 NORTH CURTIS ROAD BOISE, ID 83706		0172012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
A 168	at 10:00 AM. She corestraint was not doc Restraints for Patient accordance with a ph 3. Patient #2's medic year old male who was through the ED on 2/on 2/20/12. Accordin Physical," Patient #2' alcoholism with alcoholism wi	ewed on 4/26/12 beginning infirmed the order for umented. #3 were not used in sysician order. al record documented a 29 as admitted to the facility 106/12 and was discharged g to the "History and s primary diagnosis was ol withdrawal. lated 2/06/12 at 5:19 AM, medical restraints for Patient Limb X 4 " . Nursing at Forms" documented traints until 2/16/12 at 4:00 intinue soft 4 point restraints ocumented for the dates of ewed on 4/26/12 at 8:00 AM. ord and confirmed the ient #2's medical record did discrepancies.	A 1	168			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	G		05/01/	
	OVIDER OR SUPPLIER	CAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD 101SE, ID 83706		172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 168	called for the use of sand ankles "To Ensurorder indicated Patien when she was no lon others. A "Restraint I completed by the RN RN indicated Patient X2 and a "Vest (modidid not contain a physyest restraint on 2/04. The RAC reviewed P on 4/26/12 at 12:50 F physician's order for a documented. Restraints for Patient accordance with a physician admitted for care related to suffice care related to suffice care related to suffice care incompleted. A physician's order, of initiated soft restraint ankles. The order increstraints was "Harm" Non-Violent Form" was 4/10/12 at 8:00 AM. #5's wrists and ankle was placed in a "Ves"	lated 2/04/12 at 2:38 PM, soft restraints to both wrists be Patient Safety." The nt #4 could be released ger attempting to harm Non-Violent Form," was on 2/04/12 at 3:45 PM. The #4 was in soft limb restraints fied)." The medical record sician's order for the use of a //12 at 3:45 PM. Patient #4's medical record PM. She confirmed that a sthe vest restraint was not was restraint was not was restraint was not at the country of the facility on 4/06/12 becaute delirium, or increased ons and disordered thinking.	A	168	DELICITION 1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	G		05/01) 1/2012
	ROVIDER OR SUPPLIER	CAL CENTER	<u> </u>	10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 168	beginning at 12:50 Plorder for the vest resistants for Patient accordance with a phosphare or thopedic/joint unit a Patient #6 was admit encephalopathy (braiattributed to low-gradinflammatory state) a A physician's order, of stated "Restraint: Soft documentation was put that this order was carried to the initial "Restraint completed by the RN stated 1 soft limb resisted 1 soft limb resisted in a physician's The RAC was intervied the order for the initial to the reviewed Patient confirmed the order for 4/19/12 at 11:00 PM Restraints for Patient accordance with a physician with a	atient #5's record on 4/26/12 M. She confirmed that an traint documented on as not found in the record. #5 were not used in ysician order. #5 were not used in ysician order. cal record documented a 57 litted to the hospital on da patient on the at the time of the survey. It the time of the survey. It is the survey of the survey. It is the survey of the survey. It is the survey of the survey of the survey. It is the survey of the survey		168			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU!		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	
			D MATA	10			
		130007	B. WIN	_		05/0	1/2012
	OVIDER OR SUPPLIER DNSUS REGIONAL MEDI	ICAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 174	Continued From page	e 21	A	174	1		
	Restraint or seclusion	n must be discontinued at					
		time, regardless of the length					
	This STANDARD is	not met as evidenced by:					
		iew and review of medical					
		nined the hospital failed to e discontinued at the earliest					
		6 sample patients (#1, #2,					
	#3, #4, and #6) who	were physically restrained.					
	,	otential for patients being					
	include:	n necessary. Findings					
	I .	al record documented a 47					
	1 *	tted to the facility on 1/30/12. tory and Physical", dated					
	_	Patient #1 was admitted					
	through the ED for ca						
		ary to substance abuse.					
	The medical record of information as to whe	•					
	discharged on 2/09/1						
		nt Forms" documented					
	,	2 hours between 1/30/12 at	}				
	I .	at 2:00 PM when they were itial note, dated 1/30/12 at					
		ent #1 was placed in bilateral					
	wrist restraints with a	Il 4 side rails up on her bed.					
	After the initial note,	the type of restraint used					
		again, even though the					
		ged. The order on 1/31/12 Restraint: Soft Limb X 4."					
	The order on 2/01/12						
		X 2." The order on 2/02/12					
	at 11:55 AM, stated "	'Restraint: Soft Limb X 4."					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	G			C 1/2012
	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 155 NORTH CURTIS ROAD DISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 174	PM, "Restraint Non-Vevery 2 hours that "Restraint: Behavior for The only exception to 4:00 AM when the number of the only exception to 4:00 AM when the number of the only exception to 4:00 AM when the number of the only exception to 4:00 AM when the number of the only exception of the	at 10:16 AM, stated X 2." :00 PM to 2/05/12 at 2:00 (iolent Forms" documented N Eval for Discontinuing or restraining continues." It this occurred on 2/04/12 at rese documented "Sleeping te cooperation" and on hen the nurse documented iscontinuing restraint." (The scontinued at this time.) In #1 was restrained, Interest of the forms of the	A	174			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL				
		130007	B. WIN	G		05/0	1/2012
	OVIDER OR SUPPLIER DNSUS REGIONAL MEDI	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 155 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 174	Continued From page	e 23	A	174			
	The hospital did not of Patient #1 at the earli	liscontinue restraint to lest time.					
	year old male who wa on 3/12/12 and was o	al record documented a 74 as admitted to the hospital currently a patient as of ncluded schizophrenia and					
	3/30/12 at 8:00 PM the During that time, "Redocumented every 2 Discontinuing Restration and 2:00 February 2:00 AM when Restraint: Sleeping a cooperation." No spetthat Patient #3 requires	#1 was restrained from brough 4/06/12 at 8:00 AM. straint Non-Violent Forms" hours that "RN Eval for int: Behavior for restraining exception to this occurred PM and 3/31/12 at 12:00 AM estraint Non-Violent Forms"					
	#3 was either calm of 3/30/12 at 8:00 PM the During this time, "Direct documented Patient During this time, Patient tubes or lines that ne during this time, no "I documented Patient behaviors that require	•					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION (DENTIFICATION NUMBER:						
			A. BUIL			(s
		130007	B. WINC	³ <u> </u>		05/0 ⁻	1/2012
	ROVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 55 NORTH CURTIS ROAD DISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 174	at 10:00 AM. She condocumentation indical was not present in Paramatan and patient #3 at the earling and the e	infirmed specific ting the need for restraint stient #3's medical record. Iliscontinue restraint to est time. Iliscontinue a 29 I	A	174			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
130007		B. WIN	G		C 05/01/2012		
	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 65 NORTH CURTIS ROAD DISE, ID 83706		112012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	HOULD BE COMPLETION	
	NSUS REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A	174	DEFICIENCY		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
130007		B. WING			05/01/2012		
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
A 174	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A	174			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
130007		130007	B. WING			C 05/01/2012	
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		ION SHOULD BE COMPLET HE APPROPRIATE DATE	
A 174	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A	174			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING			С	
		130007				05/0·	1/2012
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER				10	EET ADDRESS, CITY, STATE, ZIP CODE D55 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
A 174	required continued restraint.		A	174			
A 185	The facility failed to ensure Patient #6's restraints were discontinued at the earliest possible time. 482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION		А	185			
	[there must be documedical record of the	nentation in the patient's following:]					
	A description of the patient's behavior and the intervention used.						
	Based on staff interv records, it was determ ensure a description of documented for 5 of 6 #3, #4, and #6) who w This resulted in the po	not met as evidenced by: iew and review of medical nined the hospital failed to of the patient's behavior was 6 sample patients (#1, #2, were physically restrained, otential for patients to be urily. The findings include:					
	year old male who was through the ED on 2/0 diagnoses of alcoholis He was discharged on "Critical Care Progres 1:58 PM, documented from the ED to ICU for physician "Critical Ca	sm with alcohol withdrawal. n 2/20/12. A physician's ss" note, dated 2/06/12 at d Patient #2 was transferred or continued treatment. The re Progress" note, dated indicated Patient #2 was					
	initiated soft restraints to "To Ensure Patient	lated 2/06/12 at 5:19 AM, s to both ankles and wrists : Safety". The order stated e released when Patient #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	130007 B. WING			C 05/01/2012				
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER				10	EET ADDRESS, CITY, STATE, ZIP CODE 155 NORTH CURTIS ROAD OISE, ID 83706		172012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE CROSS-REFERENCE		N OF CORRECTION (X5) ACTION SHOULD BE COMPLETION DATE (IENCY)		
A 185	"Restraint Non-Violer an RN on 2/06/12 at "Observed Behaviors to follow instructions equipment, Unable to pulling at tubes and libalance/ambulate un unable to ask for ass Subsequent "Restrain not provide consister behaviors that warran restraints. A physicia 7:41 AM, called for sankles. The nursing Forms" documented AM stated "Behavior There was no clear of behavior that warrant A physician order, da called for hand mitts restraints to wrists ar also ordered to have him at all times. Tho ordered, the "Restrain completed by an RN stated Patient #2 rem and wrist restraints a hands. At the time a documentation could identified Patient #2's the on-going use of thand ankles and hand. Another physician's completed is a subject of the control of the con	empting to Harm Self." A at Form" was completed by 6:08 AM. It stated for Restraint" were "Unable and attempts to discontinue of follow instructions and nes, Unable to maintain assisted and refuses/is stance." At Non-Violent Forms" did at documentation of ated the on-going use of an's order, dated 2/07/12 at off restraints to wrists and "Restraint Non-Violent 2/07/12 at 6:00 AM and 8:00 for restraining continues." escription of Patient #2's ed the use of restraints. Ated 2/11/12 at 7:26 AM, Ate both hands and soft ad ankles. Patient #2 was 1:1 supervision, a staff with augh 1:1 supervision was at Non-Violent Form," on 2/11/12 at 8:00 AM, anined in 4 point soft ankle and had mitts applied to both 1:1 staff was ordered, not be found that clearly a behavior that necessitated are soft restraints to his wrists	A	185				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUII				
		130007	B, WIN	<u> </u>		05/01	1/2012
	OVIDER OR SUPPLIER DINSUS REGIONAL MEDI	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 185	4:00 PM and 6:00 PM restraining continues. Patient #2's behavior use of restraints could The RAC was intervited at 8:00 AM. She revited confirmed consistent of Patient #2's behavior restraints could not be a second to be a second t	ne nursing "Restraint documented on 2/13/12 at 1, stated "Behavior for " A clear description of that warranted the ongoing d not be found. ewed on 4/26/12 beginning ewed the record and and specific documentation for that warranted the use of e found. ensure a description of the sted the use of restraints istently documented for that documented an 82 ted to the facility on 2/04/12 reased confusion and d history dementia and discharged on 2/08/12. Idated 2/04/12 at 2:38 PM, soft restraints to both wrists and to "Restraint Non-Violent mained in non-violent til 2/07/12 at 8:00 AM, when intinued. A consistent	A	185			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	G		l l	C 1/2012
	COVIDER OR SUPPLIER	ICAL CENTER		1055	T ADDRESS, CITY, STATE, ZIP CODE 5 NORTH CURTIS ROAD SE, ID 83706		112012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 185	The nursing "Restrain 2/05/12 at 4:00 AM, 6 document specific be continued restraints. assess mood and aff documented for "Cogwere "Resisting Rest Restraints." The only "RN Eval for Disconti "Behavior for restrain no consistent and cle behavior that warrant restraints. The nursing "Direct C Patient #4's record of mood and affect as of 2/04/12, 2/05/12 and behavior that warrant restraints could not both the top	antempting to Harm Others." Int Non-Violent Forms", dated 5:00 AM and 7:45 AM did not shavior indicating a need for The form also failed to ect. The only terms initive/Emotional Response" raints or Not Resisting phrase documented for nuing Restraints" was ing continues." There was ear description of Patient #2's ted the on-going use of Charting Flowsheet" in ocumented her behavior, alm and/or cooperative on 2/06/12. Documentation of ted the continued use of e found. Bewed on 4/26/12 beginning viewed the record and and specific documentation ior that warranted the use of e found. The specific documentation in the specific docu	A	185			

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	IG_		05/0) 1/2012
	OVIDER OR SUPPLIER	CAL CENTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
A 185	attributed to low-grad inflammatory state) a Inflammatory state and	n dysfunction syndrome) e sepsis (whole body nd/or electrolyte imbalance. soft wrist restraints for at 2:48 AM. The nursing at Forms" contained a limited #6's behavior that ng use of restraints. For Restraints or Not Resisting ehavior for restraining amented on 4/20/12 from 21/12 at 8:00 PM. nt #6's behavior for which and could not be found ewed on 4/30/12 beginning ewed the record and nospital's policy that an of the patient's behavior be see could not be found. ensure a description of the atted the use of restraints istently documented a 47 atted to the facility on 1/30/12. attery and Physical" dated Patient #1 was admitted are related to alcohol ary to substance abuse. ontained conflicting other Patient #1 was	A	185			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	130007				05/01/2012	
	DNSUS REGIONAL MEDI	CAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1055 NORTH CURTIS ROAD BOISE, ID 83706	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 185	On 2/06/12 at 12:13 A "Restraint: Soft Limb stated the reason for patient safety." No specified. A nursing "Restraint No 2/06/12 at 12:13 AM, "Unable to maintain be and refuses/is unable note stated wrist restrocumentation of specifications of specifications and patient #1 continued it 1:00 PM. A specification of the "Restraint Non-Patient #1 continued it 2:00 PM. A specification of the "Restraint Non-Vat 4:00 PM stated "Mill and pt [patient] can get on 2/07/12 at 2:41 AM "Restraint: Vest" was the reason for the respatient safety." Again mentioned. Patient #1's first nursi Form," on 2/07/12 wanote stated a vest respatient and was 'balance/ambulate unaunable to ask for assivest restraint was appspecific behavior that	AM, a physician order for X2" was written. The order the restraint was "To ensure pecific behavior was Non-Violent Form," dated documented Patient #1 was alance/ambulate unassisted to ask for assistance." The raints were applied. Pecific behavior that required was not included in the Violent Forms" documented in restraints until 2/06/12 at description of Patient #1's umented at that time either. Form, dated 2/06/12 Dowants trial of no restraints et out of wrist restraints." M, a physician order for a written. The order stated traint was "To ensure to no specific behavior was ung "Restraint Non-Violent s written at 4:00 AM. The traint was applied at that I Patient #1 was "Unable to dattempts to discontinue	A	185			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	DICAL CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 185	restraints until 2/07/ description of Patier documented at that Non-Violent Form," stated "MD would lik without restraints." The RAC, interviewe 12:30 PM, confirmed Patient #1. She stat documentation of sp Patient #1 required phrases "Unable to attempts to discontiin to maintain balance, refuses/is unable to of the electronic me She stated nurses w list of phrases on a inserted into the me Staff did not docume Patient #1's behavior restraint. 5. Patient #3's medi year old male who w on 3/12/12 and who 4/30/12. Diagnoses dementia. On 3/18/12 at 1:35 a "Restraint: Vest, So order stated the rea	Patient #1 continued in 12 at 6:55 PM. A specific of #1's behavior was not time. The "Restraint dated 2/06/12 at 6:55 PM are to attempt pt [patient] and on 4/24/12 beginning at did the documentation for ted she could not find pecific behavior that indicated prestraint. She stated the follow instructions and mue equipment" and "Unable for assistance" were part dical record's programming. Found click those items from a screen and the text would be dical record. Bent a specific description of that indicated a need for that indicated a need for that indicated a need for that indicated a patient as of a included schizophrenia and the safety." No specific	A 18	5		

	OF DEFICIENCIES CORRECTION	ECTION IDENTIFICATION NUMBER: COI			3) DATE SURVEY COMPLETED		
			A. BUI			c	;
		130007	B. WIN	<u> </u>		05/01	/2012
	OVIDER OR SUPPLIER DNSUS REGIONAL MEDI	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 185	Nursing "Restraint No documented Patient # at 2:00 AM. The not restraints were applie "Observed Behaviors follow instructions and equipment." A specific behavior was not docequipment he was rediscontinue was not consider the properties of the pro	estated a vest and wrist d. The note stated for Restraints: Unable to d attempts to discontinue ic description of Patient #3's numented. The type of portedly attempting to documented. "Restraint locumented Patient #3 was 10:00 AM on 3/18/12. M, Patient #3's medical physician order for X4." The order stated the restraint was "Protect from ehavior was mentioned. Non-Violent Form" #3 was restrained on 3/30/12 e stated it was a "Restraint of edid not state the type of Patient #3. The note stated sisting the restraints and estraint." However, the scontinued and no further bund to explain the phrase. Ion-Violent Form" was dated at did not state what type of repatient #3 but stated he traints. The note also stated ing continues." The specific did placing Patient #3 in	A	185			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER DINSUS REGIONAL MEDI	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 185	at 10:00 AM. She co specific behavior was Staff did not documen	ewed on 4/26/12 beginning nfirmed documentation of not documented.	A	185			
A 187	482.13(e)(16)(iv) PAT RESTRAINT OR SEC	CLUSION nentation in the patient's	A	187			
	This STANDARD is a Based on staff interview records, it was determensure the symptoms the restraints was do patients (#1, #2, #3, # physically restrained. had the potential to in restrained only when safety or the safety of Patient #1's medical year old female admir According to the "Hist 1/30/12 at 6:20 PM, Fithrough the ED for care	the restraint or seclusion. not met as evidenced by: iew and review clinical nined the hospital failed to that warranted the use of cumented for 6 of 6 sample #4, #5, and #6) who were This lack of documentation iterfere with patients being necessary to ensure their fothers. Findings include: record documented a 47 ited to the facility on 1/30/12. itory and Physical" dated Patient #1 was admitted are related to alcohol ary to substance abuse. ontained conflicting other Patient #1 was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		400007	B. WIN		_		
NAME OF P	ROVIDER OR SUPPLIER	130007			REET ADDRESS, CITY, STATE, ZIP CODE	05/0	1/2012
	ONSUS REGIONAL MEDI	CAL CENTER		1	055 NORTH CURTIS ROAD		
	T			В	BOISE, ID 83706		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	CTIVE ACTION SHOULD BE C NCED TO THE APPROPRIATE	
A 187	On 2/06/12 at 12:13 A "Restraint: Soft Limb stated the reason for patient safety." An in which identified the c warranted the use of documented by the p A nursing "Restraint I 2/06/12 at 12:13 AM, "Unable to maintain b and refuses/is unable note stated wrist rest individualized assess specific symptoms th restraint was not doc "Restraint Non-Violer Patient #1 continued 4:00 PM. On 2/07/12 at 2:41 A written for "Restraint: reason for the restrain safety." A physician at 8:54 AM, stated Pa night but it did not inc identified the conditio warranted the use of The first nursing "Res was documented in F 2/07/12 at 4:00 AM. restraint was applied stated Patient #1 was instructions and atter equipment" and was balance/ambulate un	AM, a physician order for the restraint was "To ensure dividualized assessment ondition or symptoms that restraint was not hysician. Non-Violent Form," dated documented Patient #1 was palance/ambulate unassisted to ask for assistance." The raints were applied. An ment which identified the at warranted the use of the atwarranted the use of the thick was "To ensure patient progress note dated 2/07/12 attent #1 was agitated last clude an assessment which in or symptoms that restraint. Straint Non-Violent Form," Patient #1's record on The note stated a vest at that time. The note is "Unable to follow mpts to discontinue"	A	187			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	G			C 1/ 2012
	ROVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706	03/0	112012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 187	were not documented. The RAC, interviewed 12:30 PM, confirmed Patient #1. She state documentation of sym Patient #1 required results of the symptoms that warrant 2. Patient #3's medically year old male who ware on 3/12/12 and was considered and was a dy30/12. Diagnoses in dementia. On 3/18/12 at 1:35 Afforder stated the reason or ensure patient safety. Identified the condition warranted the use of documented by the plant of the war and the symptoms of the war and the war applies "Observed Behaviors follow instructions and equipment." An assess specific conditions or the use of restraint war on 3/30/12 at 5:26 Pfor the symptoms of the symptoms of the war and the symptoms of the war and the symptoms of the use of restraint war on 3/30/12 at 5:26 Pfor the symptoms of the war and the symptoms of the symptoms of the war and the symptoms of the symptoms o	anted the use of restraint by the nurse. If on 4/24/12 beginning at the documentation for dishe could not find aptoms that indicated astraint. If Patient #1's condition or nated the use of restraints. If record documented a 74 as admitted to the hospital aurrently a patient as of included schizophrenia and If a physician order for a confident to the restraint was "To a confident to the restraint was "To a confident to the restraint was "To a confident to the restraint was not in a confident to the restraint was not in a confident to the restraint was not in a confident to the restraint was the restraint was not in a confident to the restraint with the restraint was not in a confident to the restraints. Unable to distant the restraints to discontinue assement which identified the symptoms that warranted	A	187			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
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	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD COISE, ID 83706	00/0	172012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 187	from injury." An asse conditions or symptor restraint was not doctor at the conditions of symptor restraint was not doctor. A nursing "Restraint of documented Patient of at 6:00 PM. The not at 6:00 PM. The not assessment." The not assessment. The not assessment of a commentation regard was found. The next Non-Violent Form was found. The next Non-Violent Form was tid in not state what ty Patient #3 but stated restraints. The note as restraining continues, identified Patient #3's symptoms that warran not documented. The RAC was intervie at 10:00 AM. She was note on 3/30/12 at 6:0 was discontinued. She of Patient #3 showing warranted, were not put the condition of the condition o	the restraint was "Protect ssment which identified the insight warranted the use of umented by the physician. Non-Violent Forms" 3 was restrained on 3/30/12 as stated it was a "Restraint of stated Patient #3 was aints and it stated." However, the restraints if and no further ding the intent of this phrase nursing "Restraint as dated 3/30/12 at 8:00 PM. Are of restraint was used for the was resisting the also stated "Behavior for". An assessment which specific conditions or intend the use of restraint was seved on 4/26/12 beginning is not able to explain the 20 PM stating the restraint are did confirm assessments the use of restraints was bresent in the record. The Patient #3's condition or intend the use of restraints. The latest #43's condition or intend the use of restraints. The latest #43's condition or intend the use of restraints. The latest #3's condition or intend the use of restraints.	A	187			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	ED
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	ROVIDER OR SUPPLIER	CAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 187	1:58 PM, documented from the ED to ICU for physician "Critical Ca 2/11/12 at 7:11 AM, in transferred to the med. A physician's order, dinitiated soft restraints ankles and wrists to "The order stated the when Patient #2 was Harm Self." An indivincluded the condition exhibited, was not do. The "Restraint Non-V by an RN on 2/06/12 justification for the resequipment/tube to surfrom injury." Further "Unable to follow instructions and pullin to maintain balance/a refuses/is unable to a assessment of Patien specific symptoms or the use of the restrain #2's record. A physician order, daindicated Patient #2 va staff with him at all supervision was orde Non-Violent Form", cc 2/11/12 at 8:00 AM, s	is" note, dated 2/06/12 at d Patient #2 was transferred or continued treatment. The re Progress" note, dated indicated Patient #2 was dical floor. ated 2/06/12 at 5:19 AM, is bilaterally to Patient #2's To Ensure Patient Safety". The estraints could be released in longer Attempting to indicate assessment which it is or symptoms Patient #2 cumented. itiolent Form" was completed at 6:08 AM. It stated the intraints were to "Maintain poport MED MGMT, Protect documentation included muctions and attempts to int, Unable to following at tubes and lines, Unable in the mbulate unassisted and isk for assistance." An it #2 which included the conditions which warranted into was not found in Patient inted 2/11/12 at 7:26 AM, was to have 1:1 supervision, times. Though 1:1	A	187			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		130007	B. WIN			05/01) 1/2012	
	OVIDER OR SUPPLIER	CAL CENTER		1	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		72012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
A 187	staff was ordered, do found that identified F symptoms that neces the soft restraints to hand mitts. The RAC was intervied at 8:00 AM. She conthe hospital that the use on an individualized a condition and/or sympuse of restraints. She was missing in Patier unable to explain the The hospital failed to and/or conditions that restraints were documedical record. 4. Patient #4's medic year old female admit for care related to incagitation and a relate psychosis. She was A physician's order, or called for the use of sand ankles "To Ensurorder indicated Patier restraints when she wharm others. An indipatient #4's condition	commentation could not be continent #2's condition and/or sitated the on-going use of his wrists and ankles and sewed on 4/26/12 beginning firmed it was the policy of use of restraints was based assessment of the patient description of the patient's ptoms that warranted the econfirmed the information at #2's record, but was discrepancy. Lensure the symptoms to warranted the use of mented in Patient #2's Cal record documented an 82 and discharged on 2/08/12. Letted to the facility on 2/04/12 areased confusion and discharged on 2/08/12. Letted 2/04/12 at 2:38 PM, soft restraints to both wrists are Patient Safety". The not #4 could be released from was no longer attempting to vidualized assessment of	A	187				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		130007	B. WIN				
NAME OF PE	ROVIDER OR SUPPLIER	130007		CTD	DEET ADDRESS SITY STATE 710 SODE	05/0^	1/2012
	DNSUS REGIONAL MEDI	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 187	called for the use of s Patient #4's wrists an Safety". The order st released from restrair "Attempting to Harm of comprehensive restra outlined Patient #4's of that warranted the init not be found. The RAC was intervite at 12:50 PM. She con the hospital that the un on an individualized a and should include a condition and/or symp use of restraints. She was missing in Patien unable to explain the Patient #4 was physic assessment of his syn warranted the use of 5. Patient #5's medic was a 74 year old ma facility on 4/06/12 for delirium or increased and disordered thinkin 4/13/12. A physician's order, d initiated the use of so Patient #5's wrists an indicated the reason of "Harmful to Self." An	dated 2/05/12 at 7:35 AM, oft bilateral restraints to d ankles "To Ensure Patient ated Patient #4 could be nts when she was no longer Others." Evidence of a sint assessment that clearly condition and/or symptoms tiation of the restraints could ewed on 4/26/12 beginning infirmed it was the policy of use of restraints was based assessment of the patient description of the patient description of the patient description of the patient was that warranted the exconfirmed the information of #4's record, but was discrepancy. Cally restrained without an imptoms or conditions that restraint. Call record documented he alle who was admitted to the care related to sub-acute confusion, hallucinations ing. He was discharged on lated 4/08/12 at 4:41 PM, ft bilateral restraints to discrepancy.	A	1187			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. Bull		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		130007	B. WIN	G			C 1/2012
	ROVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 187	same information with Vest." An individualize included the condition warranted the use of restraint, was not door the RAC was intervited at 12:50 PM. She composed in Patient #5' explain the discrepant assessment of his syncerify the need for restraints were applicance assessment of his syncerify the need for restraint #6's medicance year old woman who on 4/17/12 and remain orthopedic/joint unit a Patient #6 was admittencephalopathy (brain attributed to low-gradinflammatory state) at A physician ordered of the patient #6 on 4/15' indicated the justifica "Maintain Equip/Tube Release when no lon Self." An individualize #6's conditions or synrestraint was not door The RAC was intervited to spital that the tent was not spital that the tent was not door the hospital that the tent was not door the position of the RAC was intervited at 9:30 AM. She continued the properties of the position	estraints, documented the in the addition of "Restraint: ted assessment which its or symptoms which the wrist, ankle, and vest sumented. Bewed on 4/26/12 beginning infirmed the information was its record, but was unable to ccy. Bed to Patient #5 without an imptoms or conditions to straint. Belief a patient on the interest of the survey. It is the time of the su	A	187			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL	_ CENTER	•	10	ET ADDRESS, CITY, STATE, ZIP CODE 55 NORTH CURTIS ROAD DISE, ID 83706		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 187 Continued From page 44 and should include a des condition and/or symptom use of restraints. She cowas missing in Patient #6 unable to explain the discipation of the use 482.13(e)(16)(v) PATIEN OR SECLUSION [there must be document medical record of the following the ration the intervention. This STANDARD is not a Based on review of clinic policies and staff interview the hospital failed to ensure of 6 of 6 sample patients #6) who were physically documentation of the patageness of the patageness of the sample patients. #6) who were physically documentation of the patageness of the sample patients. #6) who were physically documentation of the patageness of the sample patients. #6) who were physically documentation im hospital staff to effectively and effectiveness of the sample patients. 1. Patient #1's medical review of the sample patients. 1. Patient #1's medical review of the sample patients. 2. Patient #1's medical review of the sample patients. 3. Patient #1's medical review of the sample patients. 4. Patient #1's medical review of the sample patients. 4. Patient #1's medical review of the sample patients. 5. Patient #1's medical review of the sample patients. 6. Patient #1's medical review of the sample patients.	scription of the patient's ms that warranted the infirmed the information 6's record, but was crepancy. Ind symptoms were not e of restraint. IT RIGHTS: RESTRAINT Itation in the patient's owing:] In the intervention(s) male for continued use of met as evidenced by: cal records and hospital ws, it was determined ure the medical records (#1, #2, #3, #4, #5 and restrained, included tient's response to the preded the ability of a sasess the need for restraints. Findings The product of the facility on 1/30/12 and alcoholical record contained at to whether Patient #1		187			

OLIVILIV	OT OIL MEDIOAILE &	T DIONID OLIVIOLO	\neg	_		OWD N	7. 0930-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED (X3) DATE SURV COMPLETED							
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	OUR MARRY OF	ATTAINT OF PETIOLENGIA			 		
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A 188	Continued From page	e 45	A	188			
	A physician order for	Patient #1 for restraints was PM. The order was for 4					
	until 2/05/12 at 2:00 F Non-Violent Forms" w hours while Patient # 4:00 AM and 6:00 AM #1's "Restraint Non-V	#1 continued in restraints PM. The "Restraint were documented every 2 1 was restrained. Except for 1 on 2/04/12, all of Patient riolent Forms" documented					
	"Restraint Non-Violen "Resisting restraints" No specific behaviors #1's response to the r	ing continues." All of the at Forms" stated either or "Not resisting restraint." were described. Patient restraints, including a heir continued use, was not					
	12:30 PM, confirmed Patient #1. She confi	d on 4/24/12 beginning at the documentation for irmed Patient #1's response not clearly documented.					
	Hospital staff did not or response to the restra	document Patient #1's aints.					
	year old male who wa on 3/12/12 and was o 4/30/12. The "ED Ph 3/12/12 at 10:12 PM,	stated Patient #3 had a nia and dementia. He was					
		ted 3/30/12 at 5:26 PM, Soft Limb X4 [wrists and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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	OVIDER OR SUPPLIER	CAL CENTER	_	1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		172012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 188	Patient #3 was restra PM until 4/06/12 at 8: Non-Violent Forms" w hours while Patient #3 Patient #3's "Restraint documented "Behavio All of the "Restraint N either "Resisting restr restraint." No specific Patient #3's response specific rationale for t documented. The RAC, interviewed 11:10 AM, confirmed Patient #3. She confit to the restraints was r Hospital staff did not response to the restra continued use. 3. Patient #2's medica year old male who was through the ED on 20 diagnoses of alcoholic He was discharged of A physician's order, of initiated soft restraints The "Restraint Non-V by an RN on 2/06/12 documented Patient #4	at Forms" documented ined from 3/30/12 at 8:00 00 AM. The "Restraint vere documented every 2 3 was restrained. All of thon-Violent Forms" or for restraining continues." on-Violent Forms" stated raints" or "Not resisting behaviors were described. To to the restraints, including a heir continued use, was not at the documentation for remed Patient #3's response not clearly documented. Iddocument Patient #3's aints and rationale for all record documented a 29 as admitted to the facility of 12 with primary sm with alcohol withdrawal. In 2/20/12. Istated 2/06/12 at 5:19 AM, as to both ankles and wrists. Isolent Form" was completed at 6:08 AM. The form #2's cognitive and emotional arg restraints." Patient #2's	A	188			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
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	OVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 188	Forms" documented in restraints until 2/16/12 A physician's order, discalled for soft restraints ankles. The order discresponse to restraints Non-Violent Forms" discoo AM and 8:00 AM restraining continues, emotional, and behavior and documented documented response restraints." A clear debehavior and his responder an	g "Restraint Non-Violent Patient #2 remained in 2 at 4:00 PM. ated 2/07/12 at 7:41 AM, the to Patient #2's wrists and it not document Patient #2's s. The nursing "Restraint ocumented on 2/07/12 at it stated "Behavior for "Patient #2's cognitive, ioral response to restraints at 6:00 AM. The et at 8:00 AM was "Resisting escription of Patient #2's conse to restraints was not ated 2/13/12 at 4:03 PM, test and soft restraints to and wrists. The order did not is response to restraints. In the Non-Violent Form," 12 at 4:00 PM and 6:00 PM, the estraining continues." It was documented as "Not There was no clear #2's behavior or his is exwed on 4/26/12 beginning the ewed the record and is response to restraints was ed.	A	188			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		CONSTRUCTION	(X3) DATE SI COMPLE	TED
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	ROVIDER OR SUPPLIER	ICAL CENTER		105	ET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH CURTIS ROAD ISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 188	4. Patient #4's medic year old female admit for care related to incagitation and a relate psychosis. She was A physician's order, or called for the use of sand ankles. The "Redated 2/04/12 at 3:45 Patient #4's response. A physician's order, or called for the use of sand ankles. The "Redated 2/04/12 at 3:45 Patient #4's response. A physician's order, or called for the use of sand ankles. The "Restraint Non-Violed 4:00 AM, 6:00 AM and Patient #4's cognitive restraints as "Resisting Restraints. Behaviors were not or there was no clear of behavior or his response of the response of the response of the response to restraint. The RAC was intervited to 12:50 PM. She reconfirmed Patient #4 not clearly document. Hospital staff did not response to restraint. Patient #5's medic year old male who was 4/06/12 for care relatincreased confusion,	al record documented an 82 tited to the facility on 2/04/12 creased confusion and d history of dementia and discharged on 2/08/12. dated 2/04/12 at 2:38 PM, soft restraints to both wrists straint Non-Violent Form," 6 PM, did not document de to restraints. dated 2/05/12 at 7:35 AM, soft bilateral restraints to ad ankles. The nursing at Form", dated 2/05/12 at ad 7:45 AM documented de and emotional response to ang Restraints or Not " Patient #4's specific learly described on the form. lescription of Patient #4's less to restraints, including a continued use of restraints. Lewed on 4/26/12 beginning viewed the record and less response to restraints was led. document Patient #4's s. al record documented a 74 as admitted to the facility on led to sub-acute delirium or	A	188			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER	CAL CENTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD 30ISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 188	called for the use of s Patient #5's wrists an dated, 4/08/12 at 4:57 following the order for restraints, documente the addition of a restre "Restraint Non-Violent 6:00 PM, and 4/09/12 documented Patient # response during this is Restraints" or "Sleepi description of Patient response to restraints rationale for continued The RAC was intervied at 11:10 AM. She reconfirmed Patient #5's not clearly documented Hospital staff did not or response to restraints 6. Patient #6's medic year old woman who on 4/17/12 and remai orthopedic/joint unit a Patient #6 was admitt encephalopathy (brain attributed to low-grad inflammatory state) a A physician ordered s Patient #6 on 4/19/12	ated 4/08/12 at 4:41 PM, oft bilateral restraints to d ankles. Another order PM, and immediately soft ankle and wrist at the same information with aint vest. The nursing to Form," dated 4/08/12 at at 4:00 AM to 10:00 AM, 45's cognitive and emotional time was "Resisting ng." There was no clear #5's behavior or his an including a specific diuse of restraints. Bewed on 4/25/12 beginning riewed the record and as response to restraints was ed. Cocument Patient #5's including a specific diuse of restraints was ed. Cocument Patient #5's including a specific and a patient on the strength of the survey. The second documented a 57 was admitted to the hospital ned a patient on the strength of the survey. The second documented is the time of the survey. The second second of the survey is second of the survey. The second of the survey is second of the survey is second of the survey. The second of the survey is second of the survey is second of the survey. The second of the survey is second of the survey is second of the survey is second of the survey. The second of the survey is second of the survey is second of the survey. The second of the survey is second of the survey is second of the survey is second of the survey. The second of the survey is second of the survey	A	188			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	ROVIDER OR SUPPLIER	DICAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
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A 188	response as "Resisti restraints," with one PM when "Other: is restraints" was docu description of Patien response to restraint. The RAC was interviat 11:10 PM. She reconfirmed Patient #6 not clearly document. Hospital staff did not response to restraint 482.24 MEDICAL RITHE HOSPITAL THE HOSPITAL RITHE HOSPITAL THE HOSPITAL THE HOSPITAL THE HOSPITAL THE HOSPITAL THE CONDITION IS Based on staff interrecords, policies, and determined the hospital records sent or medical records and determined the complete medical re 6 patients (#1, #2, #2 medical records were a lack of evidence the patients was response.	en-Violent Form" #6's cognitive and emotional ng restraints or "Not resisting exception on 4/20/12 at 8:00 resistant only at times to mented. There was no clear t #6's behavior or his s. ewed on 4/25/12 beginning eviewed the record and its response to restraints was ted. document Patient #6's s.		188			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
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	ROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706	05/0	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
A 431	Information Managemesponsible for the consecurity of medical redepartment was responsible for the consecurity of medical redepartment was responsible for the security services. The Director of Health stated the Health Information of the completeness of responsibility of the necession of the software nurses ustated all nursing docresponsibility of the necession of the software nurses ustated the Health Information of physician of services. However, Sinformation Management or include nurquality reviews. The DPSRC was interested the himplemented a policy responsible for oversing record including the confine of nursing documental security.	alth Information erviewed on 5/01/12 . She stated the Health ment Department was ding, storage, back-up, and cords. She stated the onsible for the accuracy and sician records as well as diology records, and Information Management rmation Management rmation Management assumed responsibility for nursing documentation. She umentation was was the ursing department and the epartment which managed sed to document. She rmation Management d and conducted quality documentation and ancillary she stated the Health ment Department did not rsing documentation in their rviewed on 5/01/12 at 3:55 nospital had not defining who was ght of the entire medical ompleteness and accuracy ution.	A	431			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 431	record clearly descresponse to service to the lack of docur response to service 3. The hospital faile record entries were relates to incomple The cumulative effect omissions resulted to document the cat 482.24(c) CONTENT The medical record justify admission as support the diagnor progress and responservices. This STANDARD Based on staff interecords, incident rewas determined the medical record clear progress and response to the include: 1. Patient #1's medical response to the include:	ed to ensure the medical ribed patients progress and es. Refer to A449 as it relates mentation describing patients' es. ed to ensure the medical ecomplete. Refer to A450 as it te medical records. ect of these systemic in the inability of the hospital are patients received.	A 445			
	1 *	o was admitted to the hospital red mental status and alcohol				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
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		130007	D. WIII	<u> </u>		05/0	1/2012
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 449	conflicting information was discharged on 2/10/12, stated on 2/10/12 while the indischarge summary son 2/09/12. a. A note in Patient # "Case Management A 2/01/12 at 4:03 PM." "Living Arrangements Level of Functioning Physical Care Provide Financial Situation Physical Care Provide Financial Situation Prescription coverage Community Resource Initial Plan Home." A "Direct Charting Flot 12:00 PM stated Patie person and was only commands. The "Care Assessment" did not supervision and assist discharge. The assescommunity resources assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not assessment did not indischarge planning new At the time of the assessment did not assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment did not indischarge planning new At the time of the assessment	nedical record contained n as to whether Patient #1 09/12 or 2/10/12. The body nmary," dictated at 10:21 d Patient #1 was discharged dentifying information on the stated she was discharged 1's medical record, labeled Assessment," was dated at stated:HouseAmbulatory erIndependent do insurance coverage, No esArranged owsheet," dated 2/01/12 at ent #1 was only oriented to able to follow 1 step se Management mention Patient #1's poor need for supervision. The state who she lived with or if stance were available upon ssment did not state what were arranged. The stentify Patient #1's	A	449			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP COL 1055 NORTH CURTIS ROAD BOISE, ID 83706		01/2012	
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A 449	3:48 PM. It stated for treatment at an Patient #1's medica she was discharged. The Case Manager beginning at 11:07 Managers were resplanning at the hos managers reviewed planning on a daily know why there was documentation for also confirmed the where Patient #1's medical nursing "Restraint I on 2/07/12. The notable at 1:00 Mactually written at 5. The physician orded dated 2/07/12 at 2: did not correspond Form." It was not actually applied at was documented. "Restraint Non-Violdifference. The RAC was interest at 12:30 PM. She was restrained was	documented Case ess note was dated 2/08/12 at Patient #1 was not appropriate alcohol rehabilitation facility. If record did not state where d to. Twas interviewed on 4/24/12 AM. She stated Case ponsible for discharge pital. She stated case d patients for discharge basis. She stated she did not s no Case management days for Patient #1. She medical record did not state as discharged. Tical record documented a Non-Violent Form," at 4:00 AM of the stated a vest restraint was est at that time. Even though it AM, the note stated it was	A 449				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WING			C 05/01/2012	
	NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER			10	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON SHOULD BE COMPLETI HE APPROPRIATE DATE	
A 449	Form," dated 1/30/12 Restraint-All side rails "Restraint Non-Violen restraint usage every 6:00 PM and 2/05/12 were discontinued. A 1/30/12 at 6:00 PM, th not documented again though the type of resover time as follows: A physician's order, d stated "Restraint: So	g "Restraint Non-Violent at 6:00 PM, stated "Type of sup, Soft limb X2." Nursing at Forms" documented 2 hours between 1/30/12 at at 2:00 PM when restraints after the initial note on the type of restraint used was in by nursing staff, even straints ordered changed lated 1/30/12 at 5:12 PM, ft Limb X 2rails X 4." lated 1/31/12 at 4:45 PM, ft Limb X 4" lated 2/01/12 at 5:25 PM, ft Limb X 2." lated 2/02/12 at 11:55 AM, ft Limb X 4." lated 2/03/12 at 1:38 PM, ft Limb X 4." lated 2/04/12 at 10:16 AM, ft Limb X 2." lated 2/05/12 at 9:12 AM, ft Limb X 2."	A	449			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	iG_			C 1/2012
NAME OF PR	OVIDER OR SUPPLIER			T			172012
	ONSUS REGIONAL MED	ICAL CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD		
		IOAL OLIVER		E	BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 449	Continued From page	e 56	Δ	449			
	A physician's order, dated 2/07/12 at 2:41 AM, stated "Restraint: Vest."			773			
	PM, stated Patient #' restraints on upper e was present explainin were ordered on 1/30 side rails were not or they had been in the A physician progress PM, did not mention of for Patient #1. No do explaining why 2 point 2/05/12 for Patient #' point restraints on 2/0	extremity." No documentation on why 4 point restraints 10/12 for Patient #1 or why dered to be continued, as previous order on 1/30/12. Indeed, a supervious order on 1/30/12 at 12:26 the type of restraints in use occumentation was present of restraints were ordered on 1 when she had been in 4 103/12 and 2/04/12. An langing restraint needs for					
	2/06/12 at 12:13 AM, balance/ambulate un unable to ask for ass Patient #1 was place "Restraint Non-Violer Patient #1 remained 2/06/12, when they will did not state why the until 4:00 AM, 1 hour order was written. No problem requiring rest the time the order was A nursing "Restraint AM on 2/07/12, state applied. The nursing	Non-Violent Form," at 4:00 d a vest restraint was note stated Patient #1 was					
	"Unable to follow inst	ructions and attempts to nt" and was "Unable to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	B. WING		C 05/01/2012	
	ONSUS REGIONAL MEDI	CAL CENTER	<u>, </u>	1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION	
A 449	note did not state what #1 was trying to discord a vest would prevent. The nursing "Direct C 2/06/12 at 4:00 PM, 8 12:00 AM, stated Patiperson, and able to for The nursing "Direct C 2/07/12 at 4:00 AM, sagitated and restless specifically what this documentation descrit would indicate the new 12:30 PM, confirmed Patient #1. She state type of restraint was a time. She confirmed restraint were not cleastated items document Non-Violent Forms" a Flowsheets" were chostomy with the patient and click on it "Unable to follow instance discontinue equipment medical record. The for staff to document behavior of patients. In addition, the RAC obeginning at 10:45 All	coulate unassisted and sk for assistance." The at type of equipment Patient ontinue or how placing her in that. Charting Flowsheet," dated 1:00 PM, and 2/07/12 at ient #1 was calm, oriented to ollow 1 step commands. The note did not describe meant. There was no bing patient behavior that ed for restraint. If on 4/24/12 beginning at the documentation for id she could not tell what used for Patient #1 at what the reasons for the use of any documented. She need on the "Restraint and the "Direct Charting is not a list on a e nurse would pick the item thavior associated with the . That item, such as ructions and attempts to not the line included in the RAC stated it was difficult	A	449			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CAL CENTER		1055	T ADDRESS, CITY, STATE, ZIP CODE S NORTH CURTIS ROAD SE, ID 83706			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 449	she did not review me the reason for restrair difficult to find information. A social work note record, dated 2/03/12 [spoke with] pt sister in his shoes when showith pt. He is friendly PT. Will follow." This for another patient as female who did not renot misfiled because #1's social worker, hamedical record in ord. The Social Worker was beginning at 11:20 All documentation and still treferred to. Information on Patient accurately describe his discharge information. 2. Patient #3's medically year old male who was on 3/12/12 and was of 4/30/12. He had diag dementia. a. Patient #3's "Care included "IPOC Adult KnowledgeIPOC Ac R/T Hospital StayIF	edical records to determine in tusage because it was too ation in the medical records. In Patient #1's medical at 11:06 AM, stated "MSW (name), requested she bring ecomes to visit next. Met and happy as finishing his is note was obviously written. Patient #1 was a confused eceive PT services. It was the author, who was Patient at to log in to Patient #1's er to enter the information. As interviewed on 4/24/12 M. She confirmed the tated she did not know who the tated she did not know who the tated she did not hospital eurrently a patient as of phoses of schizophrenia and the plans," initiated on 3/14/12, Core-Deficient dult Core-Difficulty Coping POC Adult Core-Falls-Risk asion of Social/Discharge nowledge Re: Health	A	449				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	CAL CENTER		10	EEET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD COISE, ID 83706		
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A 449	No direction to staff a for Patient #3 was do POC. For example, the POC did not specify was deficient in or hoproblem. Instead, the knowledge of Disease Progressing" and staff intermittent basis "Production of Pock and	s to how they should care cumented as part of the he Deficient Knowledge what knowledge Patient #3 w staff should approach the POC listed "Adequate Process-Achieved or fi documented on an ogressing, Unchanged, or nation was documented. In the POC goal and subsequent to in relation to his care. For utive notes by the RN were roblem of "Deficiant ncluded: In the progressing Chieved Progressing Achieved Progressing Chieved Inchanged Ifficulty Coping R/T Hospital lude direction to staff. The I "Effective Coping Progressing." RN staff I rogressing Achieved Progressing. RN staff I rogressing RN staff	A	449			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 05/01/2012	
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	ROVIDER OR SUPPLIER	EDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1055 NORTH CURTIS ROAD BOISE, ID 83706		101/2012	
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A 449	4/09/12 at 7:50 AN 4/13/12 at 6/28 PN 4/14/12 at 4:20 PN 4/16/12 at 5:24 AN Other items that w #3's POC included described above, documented from psychiatric diagno which was diagno sitters, and contact on 4/18/12. A nursing "Handor AM, stated "Pt. ha aggressive tonigh towards male sitte sitters." Patient # use of female sitte sitters." Patient # use of female sitte The POC was rev beginning at 10:30 direction to staff w She stated for iter interventions were they were listed in explain what prog achieved meant ir She stated the EN document specific The Manager of tr interviewed on 4/2 She reviewed the Patient #3 very we interacting with his	M-Achieved M-Unchanged M-Unchanged M-Unchanged M-Unchanged M-Unchanged M-Unchanged M-Ere not addressed in Patient d restraints which were problems voiding which were 3/30/12 through 4/08/12, his ses, a urinary tract infection sed on 4/14/12, the use of at isolation which was initiated ff Form," dated 3/16/12 at 7:58 d one episode of being verbally t. Pt. stated aggression was ar. Pt. is more calm with female 3's POC did not mention the	A 4	49			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		130007	B. WIN	B. WING		C 05/01/2012	
	OVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
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A 449	he would like to sit do greatly improved his east confirmed that his specific direction to stopation to ambulate Patient # did not direct staff to a ambulating him. b. Restraint document medical record was not be recorded as a state of the patient #3's "ED Physis" 12/12 at 10:12 PM. had a history of schize the note stated he had home after increased nurse in the abdomer #3 was calm at first be with the staff, was tryit required restraint and "Emergency Room Prof. 41 PM on 3/12/12, swalking in hallways and the became verbally a in wrist restraints at 6 removed at 9:15 PM to the wrist restraints was record. The RAC was intervied at 10:00 AM. She correstraint was not doct. A physician's order at for "Restraint: Soft Li	shed him softly asking him if twn. She stated this had episodes of aggression. In Pot a gait belt as to how to approach stated staff used a gait belt as She confirmed the POC use a gait belt when the state of the	A	449			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER	100007		STR	REET ADDRESS, CITY, STATE, ZIP CODE	05/01	1/2012
ST ALPHONSUS REGIONAL MEDICAL CENTER				1	055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 449	were applied at this ti "Restraint/Seclusion- at 7:55 AM, stated Pa the floor and wandere The form stated he w security." The form s four points while nurs restraints to legs and "Type of RestraintS VestRestraints App nursing note that exp applied to Patient #3' wrists, or how this wo swinging at staff, was physician order for re this nursing note was order for restraint followritten at 7:57 PM on A nursing "Restraint I 3/26/12 at 8:04 AM, s were discontinued at "Restraint Non-Violer 8:05 AM, stated "Pos at 8:00 AM including Bilateral." The complex explained in the medi did not have surgery "Post Surgical Restra The first physician "P initiation of restraints PM. The note stated "quite aggravated, etc. at about 9:00 this	wine. A nursing Violent Form," dated 3/26/12 atient #3 attempted to leave ed into other patients' rooms. as "swinging out at stated "Security held pt at sing staff applied soft chest." The form stated soft limb X2. Ilied to-Ankle, bilateral." A lained why restraints were s ankles and not to his build keep Patient #1 from a not documented. A straints corresponding to not documented. The next owing their application was a 3/26/12. Non-Violent Form," dated stated Patient #3's restraints 8:00 AM. The next at Surgical Restraint Applied" "Soft limb X2, vest,Ankles eting notes were not ical record. Also, Patient #1 so it was not clear what sint" meant. Progress Note" following the was dated 3/26/12 at 4:58 Patient #3 had become agitated, screaming, spitting, s morning." The note did not ints had been applied or	A	449			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ST ALPHONSUS REGIONAL MEDICAL CENTER				1	055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		D BE	(X5) COMPLETION DATE
A 449	The RAC was intervie at 11:10 AM. She co documentation for 3/2 not explain the discret. c. A nursing "Restrain 3/18/12 at 1:37 AM, s "Unable to follow inst discontinue equipment what equipment Patied discontinue. In fact, in doucment any equipment #3 on 3/18/12 Non-Violent Form" also behavior the patient be a danger to himse restraints to protect h Non-Violent Form" strincluding "All side rail restraints], and vest." dated 3/18/12 at 4:59 was not resisting the for restraining continues a documented on Form" at 6:13 AM and form at 11:21 AM on was able to ambulate "Absence of behavior" The corresponding plat 1:35 AM, called for be applied. An order constituted a separate documented. The RAC was intervied at 11:10 AM. She co	ewed on 4/25/12 beginning infirmed the restraint 26/12 and stated she could pancies. Int Non-Violent Form," dated stated Patient #3 was ructions and attempts to int." The form did not state ent #3 was trying to invising notes did not invent or tubes in use for it. The "Restraint is exhibited that caused him to lif or others and required im. The "Restraint ated restraints were applied in it. The next restraint form was in a patient #3 restraints but said "Behavior ites." This same language the "Restraint Non-Violent in 10:17 AM. The restraint 3/18/12 stated Patient #3 requiring restraint." In spician order, dated 3/18/12 revest and wrist restraints to to raise all side rails, which	A	449			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/04/2012 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 130007 05/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTER **BOISE, ID 83706** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 449 Continued From page 64 A 449 d. A physician order for Patient #3, dated 3/25/12 at 4:54 PM, stated "Restraint: soft limb X4...Release when no longer Attempting to Harm Self." An order for a vest restraint was not documented. A physician order, dated 3/25/12 at 4:56 PM, stated "Restraint: Therapeutic Hold. Release when no longer Attempting to Harm Self. Hands on restraint to assist patient back to room." A corresponding nursing "Restraint Non-Violent Form," dated 3/25/12 at 4:05 PM, stated Patient #3 was "...kicking and elbowing at staff." The form did not describe the events leading up to Patient #3's outburst. The form stated "Type of Restraint...Soft limb X2. Vest, Other: Security physically hands on to escort pt to room, and keep in his bed until restraints can be applied. Restraints Applied to-Ankle, bilateral, Chest." The form indicated ankle restraints had been applied but did not state he was placed in wrist restraints as called for in the order. The form stated the restraints were discontinued at 4:45 PM on 3/25/12. A nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 4:45 PM, stated restraints were applied including "Type of Restraint...Soft limb X2. Vest Restraint Applied to-Ankle, bilateral, Chest." A nursing "Restraint Non-Violent Form" for Patient #3, dated 3/25/12 at 6:10 PM, stated restraints were discontinued at that time. The medical record for Patient #3 was not clear as to when the patient was restrained and why 2 point restraints were applied when 4 point

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF AND PLAN OF CORRECTION IDENTIFICATION	N NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	30007		05/0	1/2012	
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, 1055 NORTH CURTIS ROAD BOISE, ID 83706	ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL PREF	(EACH CORRECT) CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
A 449 Continued From page 65 restraints were ordered and why a ves was applied without an order. The RAC was interviewed on 4/25/12 at 11:10 AM. She confirmed Patient # documentation and was not able to ex discrepancies. e. A nursing "Restraint Non-Violent Fo 3/26/12 at 7:55 AM, stated Patient #3 to leave the floor and wandered into of patients' rooms. The form stated secucalled and Patient #3 became aggress swinging at them. The form stated "Sept at four points while nursing staff apprestraints to legs and chest." The form "Type of RestraintSoft limb X2. VestRestraints Applied to-Ankle, bilated No physician order was present in the the restraints that were applied on 3/26 AM. Patient #3's nursing "Restraint Non-Violent Form," dated 3/26/12 at 8:04 AM, stated restraints were discontinued at 8:00 All next "Restraint Non-Violent Form," dated 3:05 AM, stated restraints were initial AM. The discrepancy was not explain medical record. The RAC was interviewed on 4/25/12 at 11:10 AM. She confirmed the documented every 2 hours between 3.	beginning 3's plain the orm," dated attempted ther unity was sive, ecurity held blied soft in stated ateral." record for 6/12 at 7:55 olent ed M. The ted 3/26/12 ated at 8:00 ed in the beginning mentation pancy. Forms" were	449			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF	
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		130007	B. WIN	<u> </u>		05/0	1/2012
	ROVIDER OR SUPPLIER DNSUS REGIONAL MED	ICAL CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 449	completed between a documentation was p was restrained during. The RAC was intervie at 11:10 AM. She co and was not able to e documentation. g. Patient #3's "Restr stated they were a re However, they did no which indicated a cor For example, Patient Forms" were docume 3/26/12 at 8:00 AM a forms did not describ behavioral status. Uninitiated or discontinu documented for "Cog were "Resisting restraints." The only Eval for Discontinuing for restraining continuing for restraining continuing for restraining continuing for restraining continuing for the RAC was intervie at 11:10 AM. She codescriptive language explained the need for h. A physician's order 3/30/12 at 5:26 PM, Climb X4." The order 1:1 intervention." A coby the physician, indi	On 3/29/12, a form was not 1:00 PM and 10:00 PM. No present to indicate Patient #3 that time. In the weed on 4/25/12 beginning of the documentation explain the lack of the week of the w	A	449			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 449	3/30/12 at 6:00 PM, in restrained at that time Non-Violent Form," distated Patient #3 was although it did not ind were in use. The not Restraints Attempted the bed alarm, the no restrictive measures in utilizing restraints and were not successful. The RAC, interviewed 11:10 AM, confirmed Patient #3. She state measures and their resistance ii. The type of restrain not documented. A physician order for 1:36 AM, stated "Rescorresponding nursin Form" on 3/26/12 at 8 of RestraintSoft limit Applied to-Ankle, bilated PM and 3/28/12 "Restraint: Vest." The "Restraint: Vest." The "Restraint Non-Violer PM documented Type ChairRestraints Application or the state of the state o	Non-Violent Form," dated indicated Patient #3 was not at A nursing "Restraint ated 3/30/12 at 8:00 PM, "Resisting restraints" icate what type of restraints at stated "Alternatives to a Bed Alarm." Aside from the did not indicate what less and been attempted prior to a did not describe how they at the documentation for a did not describe how they at the documentation for a did not describe how they at the documentation for a did not describe how they at the documentation for a did not describe how they at the documentation for a did not describe how they are a did not	A	449			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUP COMPLET	
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NAME OF PE	ROVIDER OR SUPPLIER			075			1/2012
	DNSUS REGIONAL MEDI	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD 30ISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 449	at 5:06 PM stated "Re nursing "Restraint No 3/29/12 at 12:00 AM did not document what used for Patient #3. The order, dated 4/02 "Restraint: Vest." No Non-Violent Forms," of documented what typ Patient #3. The RAC was intervie at 11:10 AM. She coused was not documented documentation of significant significant patient #3's medical documentation of significant sig	at 10:12 AM through 4/01/12 estraint: Soft Limb X4." The in-Violent Forms" from through 4/01/12 at 10:00 PM at type of restraints were 2/12 at 12:26 PM, stated one of the "Restraint completed every 2 hours AM through 10:00 PM, ie of restraints were used for ewed on 4/25/12 beginning infirmed the type of restraints	A	449			
	stated Patient #3 had date at 7:50 AM. The apparent injuries or c A "Post Fall Assessm 9:20 PM, stated Patie fall on that date. Aga were no apparent injuthe fall. The falls wer #3's medical record. The Medical Unit Marmedical record on 4/2 She stated the "Post"	nent Form," dated 3/26/12, an un-observed fall on that a form stated there were no complaints related to the fall. The form," dated 3/29/12 at an the form stated there are so complaints related to the form stated there are so complaints related to be not documented in Patient anger reviewed Patient #3's 27/12 beginning at 2:45 PM. Fall Assessment Form" was porting form and was not part					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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A 449	documentation descritaken by staff was not taken by staff was not record. 3. Patient #2's medicate of the was discharged of the was discharged of the was discharged of "Critical Care Progress 1:58 PM, documented from the ED to ICU for physician's "Critical Care Progress 1:58 PM, documented from the ED to ICU for physician's "Critical Care Progress 1:58 PM, documented from the ED to ICU for physician's "Critical Care Progress and reservices provided as an an activation of the medical record did not goals, progress and reservices provided as an activate with his wife in [a Boise]. On 2/15/12 and Management Progress will [discharge] to inla miles from Boise]. Is [clinic name] in [a tow Patient #2 was discharged from Boise]. Is clinic name] in [a tow Patient #2 was discharged from Boise]. The medical record did from the medical record did from the medical record did from the following from Boise]. The medical record did from the following from Boise]. The medical record did from the following from Boise]. The medical record did from the following from Boise]. The medical record did from the following from Boise]. The medical record did from the following from Boise].	bing the falls and action to present in the record. In the Forms'' were internal were not part of the medical are record documented a 29 as admitted to the facility 106/12 with primary sm with alcohol withdrawal. In 2/20/12. A physician's are mote, dated 2/06/12 at a department and recordinued treatment. A care Progress'' note, dated indicated Patient #2 was dical floor. Patient #2's at clearly document his esponse to the care and follows: In the treatment of the medical patient #2 at the care and follows: In the treatment is a town 270 miles from the town 270 miles from the town 106 and 106 and 106 and 107 and 108 are progress Note'' arged on 2/20/12. No other progress Note'' or other the patient #2's discharge	A 4-	49		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
A 449	beginning at 8:00 AM managers reviewed planning. She review was unable to state widischarged to. b. A nursing "Restrait 2/04/12 at 4:00 AM, and ankle restraints will will be a similar of the analysis of th	interviewed on 4/26/12 I. She stated case patients for discharge wed the medical record and where Patient #2 was Int Non-Violent Form," dated documented bilateral wrist were applied to Patient #2. A I," dated 2/06/12 at 8:06 AM, #2 was admitted to ICU on The note did not document quired restraints. Patient a physician's order, dated for soft restraints to both of Interpretation of the need for restraints. Interpretation of the physician did not ment of need for restraints. Interpretation of the physician did not ment of need 2/07/12 at 6:42 to of a restraint vest, in and ankle restraints. Interpretation of the physician of the physician did not ment of need 2/07/12, did straint vest was applied. Interpretation of the physician of the physi	A	449				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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A 449	#2's discharge planni 4. Patient #4's medica year old female admit for care related to inc agitation and a relate psychosis. She was of A physician's order, of called for the use of s and ankles. The "Red dated 2/04/12 at 3:45 wrist restraints and a The medical record d restraints applied did "History and Physical documented Patient # and hallucinating. It of restraints. An assess restraints was not doc The RAC was intervice at 12:50 PM. She rev confirmed the medical document the use of Hospital staff did not care provided in relati 5. Patient #5's medica year old male who wa 4/06/12 for care relate increased confusion, disordered thinking. 4/13/12.	clearly document Patient ng and restraint information. al record documented an 82 ted to the facility on 2/04/12, reased confusion and discharged on 2/08/12. ated 2/04/12 at 2:38 PM, off restraints to both wrists straint Non-Violent Form," PM, documented bilateral vest restraint were applied. id not state why the not match the order. The "dated 2/04/12 at 5:30 PM, 44 was agitated, paranoid did not mention the need for sment of the need for cumented. Evwed on 4/26/12 beginning viewed the record and all record did not clearly restraints. In record documented a 74 as admitted to the facility on end to sub-acute delirium or	A	449			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		E CONSTRUCTION	(X3) DATE SUF	
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A 449	Hold Complete for IN Non-Violent Form," of documented "Other: hold and IM medicated medical record did not physical hold occurred was entered. There note on 4/08/12 that A physician's order of Violent," dated 4/08/12 use of soft restraints ankles. Immediately order "Restraint Order "Restraint Order" Restraint Order "Restraint Order" of the restraint of the not of the restraint of the not occurrent of the norm," dated 4/08/12 "Therapeutic Hold." written until 8:00 PM Non-Violent Form," of was written at 8:04 Freceived a therapeut The next "Restraint In 4/08/12 at 4:35 PM. discontinued. It was next "Restraint Non-4/08/12 at 6:00 PM. ankle and vest restraint In was written at 8:04 PM. It was written at	tinue after: Therapeutic I Injection." The "Restraint lated 4/08/12 at 4:35 PM, pt received Therapeutic on administered." The of document the reason the ed prior to the time the order was no physician's progress documented the event. Or "Restraint/Seclusion 12 at 4:41 PM, called for the to Patient #5's wrists and following was a physician's er Non-Violent," dated called for use of a restraint tion was present explaining or violent behavior. No eved for restraint was physician on 4/08/12. sing documentation was go "Restraint Non-Violent 2 at 4:30 PM, documented This nursing note was not. The nursing "Restraint lated 4/08/12 at 4:35 PM, PM and stated Patient #5 ic hold and IM medication. Non-Violent Form" was dated It stated restraints were written at 11:42 PM. The Violent Form" was dated It stated bilateral wrist and each sints were applied at 4:30	A	449			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 449	at 8:00 PM. It was well to stated Patient #5 well to Patient #5 well to Patient #5 well to Patient #5 was restra. The RAC was intervie at 12:50 PM. She reve confirmed the medical document the use of Patient #5's medical redocument the use of Patient #6's medical redocument the use of 6. Patient #6's medical redocument the use of 9. Patient #6 was admittencephalopathy (brain attributed to low-grad inflammatory state) at A physician ordered story Patient #6 on 4/19 documentation was papplied at that time. The restraint was a nursin Form," dated 4/19/12 documented the use arm. The next restraint 4/20/12, documented restraints. "Restraint 4/20/12, documented restraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints used was not patient was a nursin for the entirestraints was a nursin	ritten on 4/09/12 at 2:02 AM. as resisting restraints and aining continued. The of clearly document when ined. Rewed on 4/26/12 beginning viewed the record and all record did not clearly restraints. Record did not clearly restraints. Related to the hospital ned a patient on the of the survey. Red for care related to mild on dysfunction syndrome) are sepsis (whole body and/or electrolyte imbalance. Resoft bilateral wrist restraints of the survey of the survey. Resort that a restraint was of the survey of the survey. Resort that a restraint was of the survey of the survey. Resort that a restraint was of the survey of the survey of the survey. Resort that a restraint was of the survey of the survey of the survey of the survey. Restraint was of the survey of the	A	449			

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A 449	confirmed the medi document the use of	eviewed the record and cal record did not clearly	A 44	49			
A 450	All patient medical r complete, dated, tin written or electronic responsible for prov	cal Record Services record entries must be legible, ned, and authenticated in reform by the person riding or evaluating the service t with hospital policies and	A 45	50			
	Based on staff inte records, policies, ar determined medica incomplete for 6 of and #6) whose med This resulted in a la care and the inabilit	s not met as evidenced by: rviews and review of medical nd incident reports, it was record entries were 5 patients (#1, #2, #3, #4, #5, lical records were reviewed. ck of clarity related to patient y of the hospital to determine een provided. Findings					
	year old female who on 1/30/12 for alter	ical record documented a 47 to was admitted to the hospital ed mental status and alcohol ent #1's medical record was mples include:					
	a. The date and tim documented.	e of discharge were not					
	and Physical, Disch	mation on Patient #1's History arge Summary, and physician stated she was discharged on					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SUI COMPLET	
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A 450	dictated at 10:21 PM #1 "was discharged home, and with plant medical record stopp physician order, date to discharge Patient # The last documented 2/09/12 at 2:30 PM. "Direct Charting Flow PM. It stated Patient No progress note by the Case Manager was tating the date and to discharged or where Patient #1's Discharg inaccuracies. The su the involvement of [nate helped coordinate me was in relation to faci planning. The social worker not summary above, was beginning at 11:43 PI know Patient #1 and care. The RAC was in with the social worker of Patient #1's dischars she was discharged to medical record. b. The medical record #1's movement througe Patient #1's medical in Patient #1's medical	in the "Discharge Summary," on 2/10/12, stated Patient I on 2/10/12 to her parents' for outpatient detox." The sed on 2/09/12. The last do 2/09/12 at 2:52 PM, stated ft. It did not say where to. medication given was dated The last nursing note was a sheet, dated 2/09/12 at 3:32 ft. Is IV was discontinued. In the last nursing, social services, or as present in the record ime Patient ft. was she was discharged to. The Summary contained other immary stated "I appreciate ame of social worker], who setting with her family." This litation of discharge The din the discharge interviewed on 4/24/12 ft. She stated she did not had not been involved in her present during the interview or. She stated documentation arge date and time or where o was not present in the	A	450			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	ED
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A 450	Continued From page	e 76	A	450			
	time Patient #1 was t	ransferred to an inpatient					
	unit from the ED was	not documented. A					
	"Emergency Room P	rogress Note" documented					
		1:59 PM on 1/30/12. The		ĺ			
		ing Flowsheet," dated					
	l '	stated an "Adult Admission		1			
		en ordered. Patient #1 was					
		at this time. The time of nt unit was not documented.					
	annvai on the inpatier	it drift was not documented.		[
	The RAC, interviewed	d on 4/24/12 beginning at					
	'	ble to state when Patient #1					
	was transferred to the	e inpatient unit.					
	c. Restraint documer	ntation was not clear.					
	An "Emergency Roor	m Progress Note," written by					
	,	on 1/30/12, stated Patient #1					
	was "placed in pos	ey due to multiple attempts		ľ			
		pulling on lines." The type					
		ere not specified. No other			}		
	nursing notes related						
	Į.	D. After the initial note,					
		ocumented until mentioned					
	•	int Non-Violent Form," dated The form stated Patient #1					
		straints applied and all side					
		tated it was a "Restraint	Í				
	1	t" but the medical record did					
	not state the restrain	ts had been removed after					
	being applied at 12:4	4 PM.					
	The first physician or	der for restraints was dated					
		The order was for 4 side					
	Tunio unia uniatoral irri	st restraints. The order's					
		rrespond to the time of the					
	"Emergency Room P	-					
	"Restraint Non-Violei	nt Form" dated 1/30/12 at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2 IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 450	12:30 PM, was not al discrepancy between "Restraint Non-Violer d. The medical recorrestraints used for Paragraph of the medical restraint of PM, when they were note on 1/30/12 at 6: used was not docum. A physician's order, of stated "Restraint: So A physician's order, of stated "Restraint" order, of stated	d on 4/24/12 beginning at ple to explain the time a Patient #1's order and the extraction of the explain the time and the extraction of th	A	450			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 450	A physician's order, of stated "Restraint: Ve Because of the lack of staff regarding the typ Patient #1, it was not whether restraint order. A physician progress PM, stated Patient #1 restraints on upper environment were ordered on 1/30 side rails were not ordered they had been in the A physician progress PM, did not mention to for Patient #1. No do explaining why 2 point 2/05/12 for Patient #1 point restraints on 2/0 assessment of the ch Patient #1 was not do The RAC, interviewed 12:30 PM, stated she restraints were in use She stated the document and the context of the decision of the check the stated the document and the context was she stated the document was she she she she she she she she she sh	ated 2/06/12 at 12:12 AM, ft Limb X 2." ated 2/07/12 at 2:41 AM, st." If documentation by nursing the of restraint utilized for possible to determine the ears were followed or not. Inote, dated 1/31/12 at 1:20 was in "2 point soft extremity." No documentation the gray 4 point restraints /12 for Patient #1 or why dered to be continued, as previous order on 1/30/12. Inote, dated 2/04/12 at 12:26 the type of restraints in use cumentation was present to trestraints were ordered on when she had been in 4/3/12 and 2/04/12. An anging restraint needs for forcumented. If on 4/24/12 beginning at was not able to tell what at what time for Patient #1. Intentation did not explain the ions to change restraint was not complete. It did not	A	450			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SI COMPLE	
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A 450	initiated on 1/30/12 a The form listed "ED 3 Withdrawal-IV infusion Alcohol Withdrawal-I Medical VTE Prophy Withdrawal-Nausea Orders." No docume these terms meant of was present on the " Patient #1's "Care Platient #1's "Care Platient #1's "Care Platient With IPOC Adult Core-Deficient Kallow IPOC	and completed on 2/09/12. Stroke Panel, Alcoholons, Alcohol Withdrawal, Heparin Subcut Medical laxis, Alcohol and Vomiting, Restraint entation explaining what reproviding direction to staff Care Plans" form. Jans" form continued stating efficient Knowledge, IPOC coping R/T Hospital Stay, Ills-Risk of, IPOC Risk of Suicide Prevention, IPOC locial/Discharge nowledge Re: Health the items listed under "Care ection to staff. Jans" form did not make ection to staff. Jans" form did not make ender "IPOC Risk of Injury lide Prevention," was listed side rails up or Elbow losure bed/net bed or Geri Hard X3 or Hard X4 or Laper, or Mitt X2 or Roll belt, or limb X1 or Soft limb X2." It is list meant was included. It was included in the endy restraints listed that the treatment was used on 2/07/12	A 450			

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 450	confusing and did not 2. Patient #3's medic year old male who w on 3/12/12 and was 4/30/12. The "ED PI 3/12/12 at 10:12 PM history of schizophre admitted for combati a. Two incident repo Summary" documen on 3/26/12 at 7:50 A 9:20 PM. The falls v Patient #3's medical The Manager of the on 4/27/12 beginning the medical record. the falls was not present the schizophrenia and d came from a nursing aggression and strik The note stated Patient # schizophrenia and d came from a nursing aggression and strik The note stated Patient "became aggression elave, and actually rechemical sedation." Room Progress Notes stated Patient #3 was other patients' rooms became verbally agg	d Patient #1's care plans were of provide direction to staff. cal record documented a 74 ras admitted to the hospital currently a patient as of hysician Notes," dated , stated Patient #3 had a enia and dementia. He was ive behavior. rts labeled "Current ted Patient #3 fell twice, once M, and once on 3/28/12 at vere not documented in record. Medical Unit was interviewed g at 2:45 PM. She reviewed She stated documentation of sent in the record. Notes," dated 3/12/12 at 10:12 ration was not complete. Notes," dated 3/12/12 at 10:12 ration was not estated he g home after increased ing a nurse in the abdomen. ent #3 was calm at first but we with the staff, was trying to	A	450			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED	
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A 450	wrist restraints was n record. The RAC was intervie at 10:00 AM. She co restraint was not door in another incident, a Non-Violent Form" fo at 4:05 PM, stated reincluding "Type of Restraints Applied to corresponding physic was not found in Pati "Restraint Non-Violent dated 3/25/12 at 4:45 discontinued at that it Non-Violent Form" fo at 4:45 PM, stated "P were applied at the sappeared to remain r 3/25/12. No docume explain the conflicting. The RAC was intervie at 11:10 AM. She co documentation and w discrepancies on 3/2 b. Patient #3's POC wirect staff in the care.	evening. An order for the ot present in the medical swed on 4/26/12 beginning infirmed the order for umented. Inursing "Restraint in Patient #3, dated 3/25/12 straints were applied istraintSoft limb X2. Vest Ankle, bilateral, Chest." A sian order for a vest restraint ent #3's record. A nursing int Form" for Patient #3, PM, stated restraints were sime. Another "Restraint in Patient #3, dated 3/25/12 fost Surgical Restraints" ame time. Patient #3 estrained until 8:51 PM on intation was present to ground nursing notes. Ewed on 4/25/12 beginning infirmed Patient #3's vas not able to explain the 5/12. Evas not complete. It did not be of Patient #3. Ears" form stated it was ind the plan was ongoing as listed "IPOC ocial/Discharge"	A 4	50			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	
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	ROVIDER OR SUPPLIER	DICAL CENTER	10	EET ADDRESS, CITY, STATE, ZIP C 055 NORTH CURTIS ROAD OISE, ID 83706		
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A 450	With/without Restrain Non-Violent Beh, IP- IPOC Adult Core-Dif Stay. None of the it contained direction of the it complete. For exam Complete of the place of the contained of the image of the contained of the image of the i	isk of Injury to Self/Others: nts-Risk for Inj: Restraint OC Adult Core-Falls-Risk of, fficulty coping R/T Hospital ems listed under "Care Plans" to staff. Imm was not clear and not inple, under "IPOC Social/Discharge (nowledge Re: Health in stated "Education usthma or Bone graft/joint or ir Chemical dependency am or Community resources targe planning/Other or Renal	A 450			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. E			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DNSUS REGIONAL MED	ICAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 450	The meaning of these criteria was listed expreant. "IPOC Risk of Injury of Prevention," was lister rails up or Elbow immed/net bed or Gerico or Hard X4 or Lap Be X2 or Roll belt, or Sidor Soft limb X2." No meant was included. included in the documentation in the these restraints were side rails and soft lim were used on Patient plan. The RAC, interviewed confusing and did not Dementia and schizo problems on Patient on 4/26/12 beginning staff had specific way in order to decrease become agitated. For needed to not give his stand up or sit down. needed to coax him is him choices, such as to sit down. She con	e terms was not clear. No plaining what these terms of Self/Others & Suicide and "Type of restraint-All side publicers or Enclosure thair, or Hard X2 or Hard X3 and the rail wedge or Soft limb X1 explanation of what this list. No direction to staff was mentation. No record indicated any of used for Patient #1 except to X2. The restraints that the ware not listed in the staff was not all the ware not listed in the staff. The phrenia were not listed as the provide direction to staff. The phrenia were not listed as the likelihood that he would be rexample, she stated staff and direct commands such as Rather, she stated staff not doing things and give asking him if he would like firmed instructions to staff roach Patient #3 were not	A	450			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER	CAL CENTER		1	EEET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 450	Continued From page	e 84	A	450			
	Patient #3's documen	tation was not complete.					
	year old male who was through the ED on 2/0 on 2/20/12. Accordin Physical," dated 2/06, primary diagnosis was withdrawal. a. During Patient #2's according to the "Disc 2/20/12 at 4:23 PM, he "required significant to control his tremulous resulted in sedation a protect his airways." also stated Patient #2 delirium tremens and reportedly confused a hospitalization. The stated "mental stat problems with some of day, date and some time the day, date and some time the confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated" If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated "If the does not clear, will confused and posenote later stated	In 2 at 8:06 AM, Patient #2's a alcoholism with alcohol as hospitalization and charge Summary," dated the was reported to have a doses of benzodiazepines as and DTs. This and he had to be intubated to The "Discharge Summary" at "went through significant was resuscitated." He was and disoriented much of his "Discharge Summary" also us improved, but he still had calculation and orientation to					
	him home as he still r A "Case Managemen 2:33 PM, stated Patie	comfortable discharging emains disoriented." t" note, dated 2/06/12 at ent #2 was single and his 9 miles from Boise]. A					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CAL CENTER	•	10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
A 450	PM, stated Patient #2 270 miles from Boise entered on 2/14/12 at lived in [town 9 miles A "Case Managemen 10:51 AM stated "Anthome in [town 106 m scheduled new pt app [town 270 miles from A physician's "Progre 11:53 AM stated " physician established Boise]. I do not feel thome." The medical record d Patient #2's place of the Assistant Director interviewed on 4/26/1 Patient #2's record ar where Patient #2 wer in-law's home or with Director was unable the primary place of residual discharge plan. Patient #2's primary redischarge was not do b. A physician's order initiated non-violent, 142, and stated "Soft Live In Interviole Interviolent, 142, and stated "Soft Live Interviole Interviolent, 142, and stated "Soft Live Interviolent, 143, and stated "Soft Live Interviolent, 144, and stated "Soft Live Interviolent, 145, and stated "Soft Live Interviolent, 145, and stated "Soft Live Interviolent, 146, and stated "Soft Live Interviolent, 147, and stated "Soft Live Interviolent, 148, and stated "Soft Live Interviolent, 149, and 149, an	Inote dated 2/14/12 at 2:47 Ilived with his wife in [town I. A "Social Work" note, II: 3:03 PM, stated Patient #2 from Boise]. It" note dated 2/15/12 at icipated pt will dc to inlaws les from Boise] area. I of at the [clinic name] in Boise]" It is Note" dated 2/18/12 at the has no primary care in [town 270 miles from the patient is yet safe to send id not positively identify residence. It of Case Management was 2 at 9:15 AM. She reviewed and was unable to confirm that after discharge; to his his wife. The Assistant to identify Patient #2's lence. She could not identify esidence at the time of cumented. It, dated 2/06/12 at 5:19 AM, medical restraints for Patient Limb X 4." A nursing at Form," dated 2/16/12 at	A	450				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CAL CENTER	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 450	restraints were docun 2/11/12 or 2/15/12. A Non-Violent Forms," Patient #2 remained in The RAC was intervied She reviewed the recodocumentation in Patient explain the order of the A. Patient #4's medicing year old female admitted for care related to incomplete and a related psychosis. She was successful and an A physician's order, of and ankles "To Ensur order indicated Patient when she was no long others. A nursing "Rewas completed by the The RN indicated Patient #5's medical restraints X2 and a "Vertical the The RN indicated Patient #5's medical restraints X2 and a "Vertical the The RAC reviewed Patient #5's medical restraints order for the 2/04/12 at 8:00 AM physician's order for the documented. 5. Patient #5's medicing year old male admitted in the RAC reviewed Patient #5's medicing year old male admitted year old male admitted year old male admitted in the restraints was not yet year old male admitted year old male admitted year old male admitted in the restraints was not yet year.	ers to continue soft 4 point mented for the dates of according to the "Restraint dated 2/11/12 and 2/15/12, in soft 4 point restraints. Ewed on 4/26/12 at 8:00 AM. ord and confirmed the ient #2's medical record did discrepancies. Eal record documented an 82 ted to the facility on 2/04/12	A	450			

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 130007 05/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTER **BOISE, ID 83706** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 450 Continued From page 87 A 450 confusion, hallucinations and disordered thinking. He was discharged on 4/13/12. A physician's order, dated 4/10/12 at 8:12 AM. initiated soft restraints to bilateral wrists and ankles. The order indicated the reason for the restraints was "Harmful to Self." A nursing "Restraint Non-Violent Form" was completed by the RN on 4/10/12 at 8:00 AM. The RN indicated Patient #5's wrists and ankles were restrained and he was placed in a "Vest" restraint. The medical record did not contain a physician's order for the vest restraint. The RAC reviewed Patient #5's record on 4/26/12 at 8:00 AM. She confirmed that an order for the vest restraint documented on 4/10/12 at 8:00 AM was not found in the record. 6. Patient #6's medical record documented a 57 year old woman admitted to the hospital on 4/17/12 and remained a patient on the orthopedic/joint unit at the time of the survey. Patient #6 was admitted for care related to mild encephalopathy (brain dysfunction syndrome) attributed to low-grade sepsis (whole body inflammatory state) and/or electrolyte imbalance. A physician's order, dated 4/19/12 at 2:48 PM, stated "Restraint: Soft limb X 2." No documentation was present in the medical record that this order was carried out. The initial nursing "Restraint Non-Violent Form," completed by the RN on 4/19/12 at 11:00 PM, stated 1 soft limb restraint was placed on Patient #6's right arm. The medical record did not contain a physician's order for this restraint.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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A 450	Continued From page	e 88	А	450			
A 799	She reviewed Patient	•	A	799			
		ve in effect a discharge t applies to all patients. The d procedures must be					
	Based on staff interv records and hospital the hospital failed to discharge planning pl and implemented. The	rocess had been developed nis prevented staff from g discharge planning needs					
	Refer to A806 as it hospital to conduct di evaluations.	relates to the failure of the scharge planning					
	hospital to conduct di evaluations that inclu- likelihood of a patient	relates to the failure of the scharge planning ded an evaluation of the needing post-hospital vailability of the services.					
	hospital to conduct di evaluations including patient's capacity for	an evaluation of the self-care or of the possibility ared for in the environment					

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A 799	Continued From page	e 89	A	799	3		
	hospital to develop d 5. Refer to A821 as it	t relates to the failure of the ischarge plans. t relates to the failure of the discharge planning options					
A 806	practices impeded th discharge planning s	t of these negative facility e hospital's ability to provide	A	806	3		
	evaluation to the pati (a) of this section, an patient's request, the	ovide a discharge planning ents identified in paragraph d to other patients upon the request of a person acting If, or the request of the					
	Based on staff interview of hospital polynomial failed to prove valuations for 3 of 6 whose records were planning needs. The discharge evaluation	not met as evidenced by: view, record review, and licies, it was determined the vide discharge planning patients (#1, #2, and #3) reviewed for discharge lack of an appropriate had the potential to affect all patients' post-hospitalization et. Findings include:					
	year old male who w through the ED on 2/ on 2/20/12. Accordin Physical," dated 2/06	cal record documented a 29 as admitted to the facility 106/12 and was discharged ag to the "History and 15/12 at 8:06 AM, Patient #2's as alcoholism with alcohol					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE D55 NORTH CURTIS ROAD OISE, ID 83706		
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A 806	note, dated 2/06/12 a Patient #2 was transfic continued treatment of alcohol withdrawal. A Progress" note, dated indicated Patient #2 weedical floor for control to the "Discharge Surpetient #2 remained of discharge on 2/20/12 The "Discharge Sumpetient #2 remained of discharge on 2/20/12 The "Discharge Sumpetient #2 remained of the patient #2 was reported in sedation approtect his airways." also stated Patient #2 delirium tremens and Patient #2 was reported in the patient #2 was reported in the patient #3 and progress dated 2/13/12 at 10:20 oriented x 1, but does know he is in Boise and 303 miles from Boise progress note, dated "This morning he was possibly hallucinating the patient's mental seconsult neuropsychia evaluation for possibly feel comfortable disconsult remains disoriented."	ian's "Critical Care Progress" t 1:58 PM, documented erred from the ED to ICU for of symptoms related to A physician "Critical Care d 2/11/12 at 7:11 AM, vas transferred to the inued treatment. According mary," dated 2/20/12, on the medical floor until at 3:53 PM. mary," dated 2/20/12 at 4:23 ient #2 was reported to have t doses of benzodiazepines usness and DTs. This and he had to be intubated to The "Discharge Summary" 2 "went through significant was resuscitated." redly confused and his hospitalization. A note in Patient #2's record, r7 AM, documented "neuro: sn't know the date. Does fter he says he is in [a town]." Another physician's 2/17/12 at 2:21 PM, stated s noted to be confused and h." The note later stated "If tratus does not clear, will try for more thorough e cognitive defects. I do not harging him home as he still	A	806			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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	ROVIDER OR SUPPLIER	ICAL CENTER	·	10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 806	2:33 PM, stated Patielived in [town 9 miles 11:56 AM, the "Case "Pt is apparently mar was listed, along with "Case Management" PM, stated Patient #2 mobility and ADLs'. Management" note the situation was dated 2 stated Patient #2 live Boise]. A "Social Wo at 3:03 PM, again sta 9 miles from Boise]. A "Case Managemer 10:51 AM, stated "Ar home in [town 106 m scheduled new pt ap [town 270 miles from A physician's "Progre 11:53 AM stated "Th tenuous as his wife is and they have a 1-ye of social support. He physician established Boise]. I do not feel home." There was no docume valuation that descriptions are discharge and who will support the discharge and who will support the discharge was not docume discharge was not docume will support the discharge was not document the discharge was not document.	ent #2 was single and he from Boise]. On 2/07/12 at Management" note stated ried." The name of his wife in her phone number. A note, dated 2/13/12 at 2:49 2 required assisstance with The next "Case nat mentioned his living 2/14/12 at 2:47 PM. The note id in [town 270 miles from bork" note, entered on 2/14/12 at ded Patient #2 lived in [town at the clinic name] in Boise]. I pt at the [clinic name] in Boise]" Sess Note" dated 2/18/12 at the patient's social situation is so young and working fulltime ear old son at home, not a lot the has no primary care in [town 270 miles from the patient is yet safe to send the patient is yet safe to send the name of the amount and type of the would be available to provide	A	806			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X BUILDING		` '	(X3) DATE SURVEY COMPLETED				
		130007	B. WIN	G		05/01	C 1/2012
	OVIDER OR SUPPLIER	ICAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 806	interviewed on 4/26/1 Patient #2's record and where Patient #2 were in-law's home or with identify a discharge paredical record. The facility failed to palanning evaluation to #2's condition at time condition would impared to paredical record. 2. Patient #1's medically year old female who on 1/30/12. The "Histand 1/30/12 at 6:20 PM, so a residential alcohold"became increasing level of consciousness was obtunded (mentally mentally was discharged of the "Discharge Summary PM, stated she was abody of the "Discharge Summary PM, stated she was abody of the "Discharge of home. However, the 2/09/12. The last phate 12:52 PM, stated to not say where to. The medication given was The last nursing note Flowsheet, dated 2/0 Patient #1's IV was donote by nursing, by so Case Manager was paredically in the same paredical provided the patient #1's IV was donote by nursing, by so Case Manager was paredically in the patient #1's IV was donoted the patient #1	all 2 at 9:15 AM. She reviewed and was unable to confirm at after discharge; to his his wife. She was unable to planning evaluation in the provide a thorough discharge that clearly assessed Patient at clearly assessed Patient at of discharge and how his post-hospitalization all record documented a 47 was admitted to the hospital atory and Physical," dated stated Patient #1 came from treatment center where she gly agitated with an altered ass." The note stated she ally dulled). The note stated she ally dulled). The ge Summary" stated Patient in 2/10/12 to her parents' medical record stopped on sysician order, dated 2/09/12 discharge Patient #1. It did	A	806			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP 1055 NORTH CURTIS ROAD BOISE, ID 83706		
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A 806	where she was disched A physician progress PM, stated Patient #1 and was "oriented X (Patient #1's mentation physician would consulcohol withdrawal. Progress notes docur confused throughout remained in restraints. A note in Patient #1's "Case Management A 2/01/12 at 4:03 PM. I"Living Arrangements Level of Functioning Physical Care Provide Financial Situation No prescription coverage Community Resource Initial Plan Home." The "Case Management #1's in the "Case Management" in the "C	arged to. In note, dated 1/31/12 at 1:20 If was in 2 point restraints If [Zero]." The note stated if an did not improve the sider other causes than Physician and nursing mented Patient #1 stayed her stay. She also is from 1/30/12 to 2/07/12. Is medical record was labeled Assessment" and was dated lit stated: It stated: Independent No insurance coverage, No elesArranged Internal Assessment" did not poor mental status or her The assessment did not with or if supervision and lable upon discharge. The	A 8	606		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER: COMPLETED				
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	_	130007	B. WIN	G		05/01	1/2012
	ROVIDER OR SUPPLIER DNSUS REGIONAL MED	ICAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD OISE, ID 83706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILED TO THE	D BE	(X5) COMPLETION DATE
A 806	3:48 PM. It stated Paintermittent doses of and antianxiety medic was not appropriate frehabilitation facility. requested a meeting discuss discharge. A planning evaluation with Management notes. Social work notes we 2/01/12, 2/02/12, 2/02/12, 2/02/14, 2/02/12, 2/02/15 The first social work in oinsurance. Subse possibility of Patient alcohol rehabilitation note, on 2/07/12 at 11 was still in restraints at A complete discharge not documented in social work in a complete valuation document. A discharge planning conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and was called the conducted for Patient 3. Patient #3's medicity year old male who was on 3/12/12 and year old male who was on 3/12/12 and year old male who was on 3/12/12 and year old year	accumented Case as note was dated 2/08/12 at atient #1 had been receiving antipsychotic medication cation. It stated Patient #1 for treatment at an alcohol It stated the physician had with Patient #1's parents to a complete discharge was not documented in Case are documented on 1/31/12, 3/12, 2/06/12, and 2/07/12. Inote identified Patient #1 had aquent notes discussed the #1 going to an inpatient facility. The final social work 1:35 AM, stated Patient #1 and was disoriented. are planning evaluation was pocial work notes. are Patient #1 was interviewed at 11:07 AM. She was not the discharge planning and in the medical record. all record documented a 74 as admitted to the hospital currently a patient as of	A	806			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIP .DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CAL CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD COISE, ID 83706		
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A 806	3/13/12 at 9:00 AM, so long term care facility at extended care facility at extended care facility at extended care facility at extended care facility he decided on a mental home term care facility he do him back. There were notes documented in However, a complete evaluation, including planning needs, was The Case Manager as interviewed together PM. They stated Pathocause of discharge were not able to iden planning evaluation in A complete discharge not conducted for Pathon Conducted fo	the Assessment," dated stated Patient #3 lived in a seand was "Assisted by staff lity." It stated he had sid. It stated Patient #3 was sold. It also stated the long same from refused to take e 33 Case Management the medical record. It discharge planning identification of discharge not documented. Ind Social Worker were on 4/25/12 beginning at 1:55 itent #3 was still an inpatient e planning problems. They stify a complete discharge in the medical record. In the planning evaluation was stient #3. If "DISCHARGE 11/10, stated the screening e planning needs was its by the RN using the tent tool." The policy stated to the Case Manager for	A	806			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		130007	B. WIN	G		05/01/2012		
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A 806	Indicators which may transition/discharge proteints' discharge provided by a consister patients' discharge provided by a consister patients' discharge provided by a consister patients' discharge process to provide process to provided by a consister process to process	The policy listed "Clinical didentify a potential need for planning" The policy dident approach to evaluating lanning needs or how this d. or for Case Management 1/26/12 beginning at 8:55 AM. If the general gen		808	DEFICIENCY)			
	needing post-hospita	I services had the potential ient needs after discharge.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 808	year old male who was through the ED on 2/20 on 2/20/12. According Physical," dated 2/06 primary diagnosis was withdrawal. A physical note, dated 2/06/12 a Patient #2 was transfic continued treatment of alcohol withdrawal. A Progress" note, dated indicated Patient #2 was discharged from the "Discharge Sur Patient #2 remained of discharged from the following to Patient #2 remained of discharged from the following to Patient #2 and DTs. He was regulated a physician's progress of the physician's progress of the note later stated status does not clear, for more thorough every market a physician's progress of the note later stated status does not clear, for more thorough every market a physician's progress of the note later stated status does not clear, for more thorough every market a physician's progress of the note later stated status does not clear, for more thorough every market progress of the physician's progress of the note later stated status does not clear, for more thorough every market progress of the physician's pr	cal record documented a 29 as admitted to the facility 06/12 and was discharged ag to the "History and /12 at 8:06 AM, Patient #2's s alcoholism with alcohol ian's "Critical Care Progress" it 1:58 PM, documented ferred from the ED to ICU for of symptoms related to A physician's "Critical Care d 2/11/12 at 7:11 AM, was transferred to the inued treatment. According mmary," dated 2/20/12, on the medical floor until facility on 2/20/12 at 3:53 #2's "Discharge Summary," S PM, he was reported to ifficant doses of control his tremulousness portedly confused and his hospitalization. Patient as documented in a note, dated 2/17/12 at 2:21 , "This morning he was and possibly hallucinating." "If the patient's mental , will consult neuropsychiatry aluation for possible o not feel comfortable	A 808			
	disoriented." A physician's "Progre	ss Note," dated 2/18/12 at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
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A 808	11:53 AM, stated "Tenuous as his wife and they have a 1-yof social support. In physician establish hospital.] I do not fisend home." A discharge planning in Patient #2's recondary at the A "Case Manageme 2:49 PM, stated, "recondered A "Case Manageme 1:51 All to inlaws home in [town 270 miles from Management" note of Patient #2's need to Patient #2's need to Patient #2's need town 270 miles from Management and as post-discharge need meet those needs. The Assistant Directing interviewed on 4/26 Patient #2's record where Patient #2 win-law's home in [towith Patient #2's windered there evaluation. 2. Patient #1's medicary and the	The patient's social situation is is young and working fulltime year old son at home, not a lot de has no primary care ed in [town 270 miles from eel the patient is yet safe to an evaluation was not present rd. The patient is yet safe to an evaluation was not present rd. The patient is yet safe to an evaluation was not present rd. The patient is yet safe to an evaluation was not present rd. The patient is yet safe to an evaluation was not present rd. The patient's social situation is yet after the patient is yet safe to an evaluation was not present rd. The patient's social situation is yet and the patient is yet safe to an evaluation was not present rd.	A	808			

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A 808	on 1/30/12. The "His 1/30/12 at 6:20 PM, sa residential alcohold "became increasing level of consciousnes was obtunded (mental 2/10/12. The "Dischal 2/10/12 at 10:21 PM, information about the nursing services, by a Case Manager was puthed at earn time Pawhere she was dischalled and time Pawhere she was dischalled and time Pawhere she was ambulated. The assessment statinsurance coverage acoverage. It stated swas arranged and sawas "home." The "Case Manager finterviewed on 4/24/She stated the plan for discharge her back to treatment center rath Patient #1's record adischarge planning elikelihood of Patient #1	tory and Physical," dated stated Patient #1 came from creatment center where she gly agitated with an altered ss." The note stated she ally dulled). arged on either 2/09/12 or arge Summary," dated contained conflicting dates. No progress note by social services, or by the present in the record stating tient #1 was discharged or arged to. at Assessment," dated stated Patient #1 lived in a pry, and was independent. The patient #1 had no and no prescription substance abuse treatment id Patient #1's initial plan are Management mention Patient #1's poor need for supervision. The include the likelihood of ost-hospital services.	A	808			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒD
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A 808	discharge planning of items that should be needing a discharge been developed. A discharge planning likelihood of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the nee was not conducted for the second of the second of the second of the needs of the need	evaluation which included assessed for all patients planning evaluation had not gevaluation, including the d for post-hospital services, or Patient #1. cal record documented a 74 vas admitted to the hospital currently a patient as of hysician Notes," dated to the services and dementia. He was ive behavior. Int Assessment, "dated stated Patient #3 lived in a service patient #3 lived in a service patient #3 lived in a service patient #3 was hold. It stated Patient #3 was hold. It stated Patient #3 was hold. It also stated the long came from refused to take essment did not include the #3 needing post-hospital hotes and Social Work notes billy of Patient #3 being for the property of the patient #3 being for the patient #4 being for the pa	A	808			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 808	interviewed together PM. They stated Pat because of discharge were not able to iden planning evaluation in including the likelihood post-hospital services. A discharge planning likelihood of the need was not conducted for 4. The hospital policy PLANNING", revised Manager] will complet the assessment of the his or her own evalua as they coordinate a identified as having a discharge planning." staff to evaluate patien post-hospital. The Assistant Director was interviewed on 4 She confirmed the pot evaluate patients for post-hospital services. The hospital had not planning evaluation processed were not able to the pot and the pot evaluate patients for post-hospital had not planning evaluation processed were not able to discourse the pot evaluate patients for post-hospital had not planning evaluation processed were not able to discourse the pot evaluate patients for post-hospital had not planning evaluation processed were not able to discourse the pot evaluate patients for post-hospital had not planning evaluation processed were not able to discourse the processed were not able to discours	and Social Worker were on 4/25/12 beginning at 1:55 ient #3 was still an inpatient in planning problems. They tify a complete discharge in the medical record ind of Patient #3 needing is. evaluation, including the for post-hospital services, in Patient #3. , "DISCHARGE 11/10, stated "The [Case te a further review utilizing te admitting nurse as well as action of patient/family needs plan for patients who are ineed for more complex The policy did not direct tents for the likelihood of all services. The policy did not direct tents for Case Management in for Case Mana	A	808			
A 809	482.43(b)(4) SELF C EVALUATION		A	809			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 809	capacity for self-care patient being cared for which he or she enter which he or she enter the state of the state of the self-care and the cared for in their horn discharge. This affect and #3) whose record discharge planning, affect all patients. The in unmet patient neer include: 1. Patient #2's medity year old male who with the ED on 2/20/12. According Physical," dated 2/06/12 and year old male who with the with the discharge of the self-care was transfer to the self-care that th	ikelihood of a patient's or of the possibility of the or in the environment from red the hospital. not met as evidenced by: view, and review of medical policies, it was determined evaluate patients' capacity possibility of patients being ne environment after ted 3 of 6 patients (#1, #2,	A	809.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 809	have "required s benzodiazepines than DTs. This reside intubated to promise the intubated." A physician's programmed than the intubated of t	c:23 PM, he was reported to significant doses of to control his tremulousness sulted in sedation and he had to obect his airways." The ary" also stated Patient #2 gnificant delirium tremens and aress note, dated 2/13/12 at ented "neuro: oriented x 1, but date. Does know he is in Boise in [town 303 miles from obysician's progress note, dated M, documented Patient #2's enote stated "This morning he onfused and possibly enote later stated "If the atus does not clear, will consult or more thorough evaluation for defects. The patient may have sode during his presentation. Infortable discharging him home disoriented." gress Note," dated 2/18/12 at "The patient's social situation is e is young and working fulltime eyear old son at home, not a lot. I do not feel the patient is yet and any of the patient is yet and the patient is yet and the patient is yet any of the patien	A	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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A 809	stated "he will be reprogram. He has beed drive, return to work, abstain from all alcohomation [Physician's name] wadditional history." The Assistant Director interviewed on 4/26/1 Patient #2's record and where Patient #2 wer in-law's home in [tow hospital] or with his wadise]. Supporting defound that explained Patient #2's ability to Additionally, there was availability of family to the facility failed to earlie for self-care and ability environment with or was a residential alcohol to the facility failed to earlie for self-care and ability environment with or was a residential alcohol to the facility failed to earlie for self-care and ability environment with or was a residential alcohol to the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the facility failed to earlie for self-care and ability environment with or was a color of the failed to earlie for self-care and ability of family to	dated 2/20/12 at 4:27 PM, eferred to Brain Injury Rehable in instructed that he is not to operate power tools and sol. Discharge to home. ill interview pt's wife for or of Case Management was 2 at 9:15 AM. She reviewed and was unable to confirm at after discharge; to his in 270 miles from the vife in [town 9 miles from ocumentation could not be whether the facility verified care for himself in the home. It is no mention of the in supervise Patient #2 in the evaluate Patient #2's capacity the function in the home without supervision. In all record documented a 47 was admitted to the hospital story and Physical," dated stated Patient #1 came from treatment center where she gly agitated with an altered as." The note stated she	A 8	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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A 809	Patient #1 was confus discharge planning reprogress note, dated Patient #1 was in 2 progress note, dated Patient #2 was amagement 2/01/12 at 4:03 PM, shouse, was ambulated The assessment state insurance coverage at coverage. It stated swas arranged and sawas "home." The "Ca Assessment" did not impaired mental state supervision. The assessment of the like capacity for self-care. The Case Manager for interviewed on 4/24/1 She confirmed a disc that included the likel capacity for self-care Patient #1's record. A discharge planning likelihood of Patient # was not conducted. 3. Patient #3's medical year old male who was on 3/12/12 and was caused was a	sed and presented with seds. A physician's 1/31/12 at 1:20 PM, stated bint restraints and was It Assessment," dated stated Patient #1 lived in a ry, and was independent. Sed Patient #1 had no and no prescription substance abuse treatment at Patient #1's initial plan asse Management mention Patient #1's so or the need for sessment did not include an selihood of Patient #1's For Patient #1 was 2 beginning at 11:07 AM. Sharge planning evaluation shood of Patient #1's could not be found in sevaluation, including the self-scapacity for self-care, all record documented a 74 as admitted to the hospital surrently a patient as of	A 80	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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A 809	admitted for combative A "Case Management 3/13/12 at 9:00 AM, store long term care facility "Assisted by staff at estated Patient #3 was also stated the long to from refused to take in the assessment did in Patient #3's capacity evaluate Patient #3's activities of daily living much supervision he he needed to be discinct. Subsequent Cast well as Social Services these items. The Case Manager a interviewed together of PM. They stated Patibecause of discharge were not able to idente evaluation in the med the likelihood of Paties self-care. A discharge planning including his ability to conducted. 4. The hospital policy PLANNING", revised Manager] will complete the self-care will be self-care will be self-care will be self-care.	nia and dementia. He was we behavior. It Assessment," dated tated Patient #3 lived in a prior to admission and was extended care facility." It is placed on a mental hold. It erm care facility he came nim back. In the include the likelihood of for self-care. It did not ability to perform his own ig. It did not evaluate how might need such as whether harged to a locked facility or ise Management notes as is notes did not evaluate and Social Worker were on 4/25/12 beginning at 1:55 ient #3 was still an inpatient in planning problems. They tify a discharge planning ical record which included int #3's capacity for evaluation for Patient #3, care for himself, was not	A 80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 809	needs as they coordi are identified as havi discharge planning." staff to evaluate patie the likelihood of returname from. The Assistant Director was interviewed on 4 She confirmed the polevaluate patients for capacity for self-care return to the environment of the polevaluation of patients likelihood of returning came from. 482.43(c) DISCHARO Discharge Plan This STANDARD is Based on staff intervitospital policy review hospital failed to devoleto for discharge the potential for patie events after discharge 1. Patient #2's medicy year old male who withrough the ED on 2/on 2/20/12. According	n evaluation of patient/family nate a plan for patients who ag a need for more complex. The policy did not direct ents for self care ability and ning to the environment they or for Case Management //26/12 beginning at 8:55 AM. Solicy did not direct staff to the likelihood of patients' or the possibility they could ment from where they came. developed a discharge process that included an experience abilities and the growth the environment they GE PLAN not met as evidenced by: friew and medical record and record in the possibility in the possibility they could need to the environment they are planning. This resulted in the possibility in the possibility in the possibility they could need to the environment they are planning. This resulted in the possibility in the possibility of the facility of the		809				

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A 817	primary diagnosis wawithdrawal. A physic note, dated 2/06/12 a Patient #2 was transic continued treatment alcohol withdrawal. Progress" note, date indicated Patient #2 medical floor for cont to the "Discharge Su Patient #2 remained discharged from the PM. According to Patient dated 2/20/12 at 4:23 have "required sign benzodiazepines to and DTs. This result be intubated to prote "Discharge Summany"went through sign was resuscitated." A physician's progres 10:27 AM, document doesn't know the dat after he says he isin Boise]." Another phy 2/17/12 at 2:21 PM sonoted to be confused The note later stated status does not clear for more thorough experience.	is alcoholism with alcohol isian's "Critical Care Progress" at 1:58 PM, documented ferred from the ED to ICU for of symptoms related to A physician's "Critical Care d 2/11/12 at 7:11 AM, was transferred to the inued treatment. According mmary," dated 2/20/12, on the medical floor until facility on 2/20/12 at 3:53 #2's "Discharge Summary," B PM, he was reported to inficant doses of control his tremulousness and in sedation and he had to oct his airways." The d' also stated Patient #2 ifficant delirium tremens and as note, dated 2/13/12 at and "neuro: oriented x 1, but	A	817			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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A 817	A "Case Managem 2:33 PM, stated Pahome city was [tow 2/07/12 at 11:56 Al stated "Pt is appare his wife was listed, A "Case Managem 2:49 PM, stated Pawith mobility and A Management" note situation was dated stated Patient #2 limiles from Boise]. on 2/14/12 at 3:03 [town 9 miles from A "Case Managem 10:51 AM stated "Ahome in [town 106 scheduled new pt a [town 270 miles from 270 miles from 4 physician's "Prog 11:53 AM, stated, tenuous as his wife and they have a 1-of social support. In physician establish Boise]. I do not fee home." A discharge plan wirecord. The location was discharged to #2's record. Without 200 without 200 miles from 200 mile	ent" note, dated 2/06/12 at trient #2 was single and his in 9 miles from Boise]. On M, a "Case Management" note ently married." The name of along with her phone number. ent" note, dated 2/13/12 at trient #2 required assistance DLs. The next "Case of that mentioned his living it 2/14/12 at 2:47 PM. The note wed with his wife in [town 270 A "Social Work" note, entered PM, stated Patient #2 lived in Boise]. The next "Case of that mentioned his living it 2/14/12 at 2:47 PM. The note wed with his wife in [town 270 A "Social Work" note, entered PM, stated Patient #2 lived in Boise]. The patient will do to inlaws in miles from Boise] area. It is appt at the [Clinic name] in im Boise]" The patient's social situation is it is young and working fulltime year old son at home, not a lot the has no primary care are did in [town 270 miles from the lither patient is yet safe to send was not found in Patient #2 could not be found in Patient #2 could not be found in Patient #2 his access to community	A	817				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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A 817	The Assistant Director interviewed on 4/26/1 Patient #2's record at where Patient #2 wer in-law's home or with Director was unable to primary place of residual discharge plan. The facility failed to personal plan for Patient #2. 2. Patient #1's medicate year old female who con 1/30/12. The "His 1/30/12 at 6:20 PM, so a residential alcohol to "became increasing level of consciousness was obtunded (mental patient #1's "Discharge at 10:21 PM, stated so 2/09/12. The body of stated Patient #1 was her parents' home. If stopped on 2/09/12, dated 2/09/12 at 2:52 Patient #1. It did not documented medicate at 2:30 PM. The last Charting Flowsheet, stated Patient #1's IV progress note by nurse.	ar of Case Management was 2 at 9:15 AM. She reviewed at was unable to confirm at after discharge; to his his wife. The Assistant o identify Patient #2's dence. She could not identify rovide a thorough discharge at record documented a 47 was admitted to the hospital tory and Physical," dated stated Patient #1 came from reatment center where she gly agitated with an altered is." The note stated she ally dulled). Itime of discharge were not entifying information on ge Summary," dated 2/10/12 the was discharged on 2/10/12 to dowever, the medical record The last physician order, in PM, stated to discharge say where to. The last ion given was dated 2/09/12 nursing note was a "Direct dated 2/09/12 at 3:32 PM. It is was discontinued. No sing, by social services, or rewas present in the record	A	817				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 817	Patient #1's "Direct O 2/09/12 at 12:00 noor memory loss, garbled to follow 1 step comm Non-violent Forms" destrained from 1/30/10 A "Case Managemer 2/01/12 at 4:03 PM, shouse, was ambulated The assessment statinsurance coverage acoverage. It stated swas arranged and sawas "home." The "C Assessment" did not plan. The next and final do Management" note we PM. It stated Patient intermittent doses of and anti-anxiety med was not appropriate to rehabilitation facility. requested a meeting discuss discharge. Adocumented in Case Social work notes we 2/01/12, 2/02/12, 2/00 A social work note, distated Patient #1 coutreatment center whe cleared. The note st	she was discharged to. charting Flowsheet," dated h, stated she had short term dispeech, and was only able hands. "Restraint ocumented Patient #1 was 12 to 2/07/12. At Assessment," dated stated Patient #1 lived in a stry, and was independent. ed Patient #1 had no and no prescription substance abuse treatment id Patient #1's initial plan ase Management include a specific discharge cumented "Case ras dated 2/08/12 at 3:48 #1 had been receiving antipsychotic medication ication. It stated Patient #1 for treatment at an alcohol It stated the physician had with Patient #1's parents to a discharge plan was not Management notes. ere documented on 1/31/12, 3/12, 2/06/12, and 2/07/12. ated 2/02/12 at 3:17 PM, and go to a residential alcohol en she was medically	A	817			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	CAL CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 055 NORTH CURTIS ROAD BOISE, ID 83706			
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A 817	she is disoriented, in mentally clear to discharge plan, included patient #1's medical developed. The final at 11:35 AM, stated for restraints and her medical restraints and her medical to return to center she came from the Case Manager for medical record and with beginning at 11:07 Adischarge plan was reflected by the stated it was det medically appropriate stated she thought P with her parents but softhis. She could not discharged to her own home. The Social W with the Case Manage they thought Patient residential alcohol trestated all of a sudder they were "out of the happened to her. A discharge plan was #1. 3. Patient #3's medicyear old male who won 3/12/12 and was allowed as a sudder they was allowed and was allowed and male who won 3/12/12 and was allowed as a sudder they was allowed and male who won 3/12/12 and was allowed as a sudder they was allowed and was allowed and male who won 3/12/12 and was allowed as a sudder they was allowed and was allowed as a sudder they was allowed and was allowed and was allowed and was allowed and was allowed as a sudder they was allowed and w	restraints. Will follow when uss plan." A complete ding an alternative based on condition, was not social work note, on 2/07/12 Patient #1 was still in ental status was "not stated Patient #1 was not a the alcohol treatment in. or Patient #1 reviewed the vas interviewed on 4/24/12 M. She confirmed a not documented for Patient sitial plan was to send Patient cohol treatment program. ermined Patient #1 was not a for that program. She attent #1 was discharged she said she was not certain it say whether Patient #1 was in home or to her parents' forker joined the interview yer at 11:20 PM. They stated	A	817				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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A 817	3/12/12 at 10:12 PM, history of schizophre admitted for combative. There were 33 Case documented in the m 3/13/12 and 4/18/12. Form," dated 3/14/12 #3 had come from a street documented or at least 12 long term #3's POA. However, identified as a discharted to discharge and strated barriers, was not present to the total tota	stated Patient #3 had a nia and dementia. He was we behavior. Management notes edical record between A "Case Management at 9:04 AM, stated Patient long term care facility and at him back. Numerous ontacts and discussions with care providers and Patient a document that could be rge plan, including barriers tegies to overcome those sent in the medical record. Ind Social Worker were on 4/25/12 beginning at 1:55 itent #3 was still an inpatient at planning problems. They tify a discharge plan in the sent developed for Patient The Third Harde Harden and how they were to be only reference to discharge curred under section V. It expected to read and be unentation and plans of other m "discharge plan" was not	A	817			

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUR COMPLETE	
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A 817	She confirmed the ho document that could plan or how discharg	/26/12 beginning at 8:55 AM. ospital had not specified a be identified as a discharge e plans could be identified. developed a process to	A	317			
A 821	482.43(c)(4) REASSI DISCHARGE PLAN The hospital must readischarge plan if ther continuing care need the discharge plan. This STANDARD is Based on staff intervectors and hospital the hospital failed to was reassessed as the planning needs chan patients (Patient #1) reviewed. This prevedeveloping new plandischarge planning in Patient #1's medical year old female who on 1/30/12. The "His 1/30/12 at 6:20 PM, sa residential alcoholi"became increasing level of consciousness was obtunded (mentical patient #1's date and documented. The id	assess the patient's re are factors that may affect s or the appropriateness of not met as evidenced by: riew and review of medical policies, it was determined repatient's discharge plan re patient's discharge ged for 1 of 4 discharged whose medical records were reted the hospital from s in response to changing reeds. Findings include: record documented a 47 was admitted to the hospital story and Physical," dated stated Patient #1 came from treatment center where she gly agitated with an altered ss." The note stated she	A	321			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SUI COMPLET	ED
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A 821	at 10:21 PM, stated s 2/09/12. The body o stated Patient #1 was her parents' home. Is stopped on 2/09/12. nursing, by social set Manager was presen date and time Patien where she was disch Patient #1's "Direct C 2/09/12 at 12:00 noo memory loss, garblet to follow 1 step comm Non-violent Forms" or restrained from 1/30/ A "Case Managemer 2/01/12 at 4:03 PM, s house, was ambulate The assessment stat insurance coverage at coverage. It stated " arranged but it did no said Patient #1's initi not include the possi to the residential treat from. The "Case Ma not include a specific The next and final do Management" progre at 3:48 PM. It stated receiving intermittent medication and anti- Patient #1 was not a residential alcohol tre stopped on 2/09/12. The patient #1 was not a residential alcohol tre stopped on 2/09/12. The patient #1 was not a residential alcohol tre stopped on 2/09/12. The patient #1 was not a residential alcohol tre stopped on 2/09/12. The patient #1 was not a residential alcohol tre stopped on 2/09/12. The patient #1 was not a residential alcohol tre	she was discharged on fithe "Discharge Summary" is discharged on 2/10/12 to dowever, the medical record No progress note by vices, or by the Case it in the record stating the tit #1 was discharged or arged to. Charting Flowsheet," dated in, stated she had short term id speech, and was only able mands. "Restraint documented Patient #1 was 12 to 2/07/12. Int Assessment," dated is stated Patient #1 lived in a bory, and was independent. It is deep the progression of	A	821			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
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A 821	#1's parents to discurplan was not documenotes. Social work notes we 2/01/12, 2/02/12, 2/02 A social work note, ostated Patient #1 contreatment center who cleared. The note st medically cleared ye she is disoriented, in mentally clear to disoriented, in mentally clear to disoriented in mentally clear to disoriented. The fina AM, stated Patient #1's medical developed. The fina AM, stated Patient #1 was tated Patient #1 was tated Patient #1 was the alcohol treatment discharge plan was services and resident when it became know for a residential alcomedical record and when it became known for a residential alcomedical record and when it became known for a residential alcomedical record and when it however, she stated determined Patient #1 to a program. She stated determined Patient #1 appropriate for that pand her inability to confirmed further assets.	ere documented on 1/31/12, 2/3/12, 2/06/12, and 2/07/12. dated 2/02/12 at 3:17 PM, and go to a residential alcoholen she was medically tated she was "not at estraints. Will follow when cluss plan." A complete ading an alternative based on condition, was not all note, on 2/07/12 at 11:35 and as "not clearing." The note as not a candidate to return to at center she came from. A not developed to locate other atial options for Patient #1, which she was not a candidate hol treatment program. The Patient #1 reviewed the was interviewed on 4/24/12 and She confirmed a not documented for Patient tated the initial plan was to residential alcohol treatment dit was eventually and more disconsistent was not medically program due to her confusion	A 82			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	ΓED
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A 821	was discharged with was not certain of th whether Patient #1 vhome or to her parer whether supervision after discharge. The interview with the Ca They stated they init going to the resident program. They state was gone and they vregarding what happ Patient #1's discharged.	her parents but she said she is. She could not say was discharged to her own ints' home. She could not say was available for Patient #1 is Social Worker joined the ase Manager at 11:20 PM. ially thought Patient #1 was ital alcohol treatment and all of a sudden Patient #1 were "out of the loop" is pened to her.	A	821			



June 15, 2012

Sylvia Creswell Idaho Department of Health and Welfare 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-0036



Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction (POC), which is intended to address deficiencies cited during a complaint investigation concluded on May 1, 2012.

The hospital does not admit or concede to any deficiencies, but to the extent that any actual deficiencies do exist, Saint Alphonsus Regional Medical Center is taking appropriate action to correct those deficiencies, including the steps outlined in the attached POC. This plan of correction addresses the Bureau of Facility Standards tags BB283 and BB461 and Medicare tags A115, A164, A166, A168, A174, A185, A187, A188, A431, A449, A450, A799, A806, A808, A809, A817, and A821.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. We appreciate your thoughtful consideration of this plan of correction. We look forward to your acceptance of our plan and the revisit to verify our compliance. Please contact me at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Aline Lee, RN

Director of Patient Safety, Regulatory Compliance, and Infection Prevention Saint Alphonsus Health System

Tag	Plan of Correction	Completion Date
A115 A hospital must protect and promote each patient's rights.	Plan of Correction The Chief Nursing Officer is responsible for the implementation of the corrective action plan regarding restraint. Saint Alphonsus Regional Medical Center (SARMC), a member of the Trinity Health System, uses a computerized documentation system called Powerchart. Powerchart is a Cerner product that is used by 35 of the 40+ hospitals in the Trinity Health System. Powerchart, along with most computerized documentation systems, utilizes pick lists from which the care provider can choose the most appropriate sentence/phrase to describe the assessment of the patient or intervention(s) provided. Pick lists support consistency and efficiency in documentation. Changes to the pick lists in Powerchart can only be made at the Health System level, as the changes affect all hospitals in the system. SARMC's mid-range plan is to work with Health System leaders to recommend changes in the Powerchart pick lists to make the wording more specific e.g. to describe in more detail the behavior necessitating the use of restraints. In the short term, our corrective actions are focused on training nursing staff to better understand the existing system and to provide more detailed documentation through free text in addition to use of the pick lists. An on-line, computerized education module (e-learning) was developed. See Attachment A. The module was assigned to approximately 500 nurses on 5/12/12 to be completed by 6/15/12. The module covers the following topics: • (A164) Alternatives to Restraints Attempted—how to add a note (free text) to describe the alternative intervention attempted, when it was attempted and its effectiveness • (A166) The appropriate plan of care template to select in Powerchart when restraints are	_
	 initiated, how to individualize it for the patient, when and how to revise the plan of care when the needs of the patient change. (A168) The regulations regarding LIP orders for restraint, timing and frequency of orders for non-violent and violent restraints, that specific orders are required for each type of restraint, and 	
	 how to select multiple restraints in Powerchart. (A174) Discontinuing restraints as soon as possible and when less restrictive measures are effective; how to add free text to document detail on the rationale for removing restraints, the less restrictive measures used and their effectiveness. (A185 and A187) When restraints are initiated, how to add free text to document the patient's specific observed behaviors necessitating the use of restraint, the specific type of restraint used, 	

Tag	Plan of Correction	Completion
		Date
	• (A188) How to add free text to describe the patient's behavior necessitating the continuing use of restraints and response to restraints. The e-learning module includes a post-test. Completion of the module is being tracked and reported back to the managers.	
	To reinforce the training, name badge cards and checklist notepads have been created to provide a quick reference for nursing staff on the restraint requirements.	
	To reinforce the training and monitor progress, a comprehensive audit tool was developed. Attachment B. Nurses who work with patients in restraint are expected to complete one audit by 7/13/12. Subsequently, auditing of restraints will continue on a quarterly basis. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115.	
A164 Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	Please refer to tag A115.	
A166 The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care.	Please refer to tag A115.	

Tag	Plan of Correction	Completion
	DI C	Date
A168 The use of restraint	Please refer to tag A115.	
or seclusion must be in		
accordance with the order		
of a physician or other		
licensed independent		
practitioner who is		
responsible for the care of		
the patient and authorized		
to order restraint or		
seclusion by hospital		
policy in accordance with		
State law.		
A174 Restraint or	Please refer to tag A115.	
seclusion must be		
discontinued at the earliest		
possible time, regardless		
of the length of time		
identified in the order.		
A185 There must be	Please refer to tag A115.	
documentation in the		
patient's medical record of		
the following: A		
description of the patient's		
behavior and the		
interventions use.		
A187 There must be	Please refer to tag A115.	
documentation in the		
patient's medical record of		
the following: The		
patient's condition or		
symptom(s) that warranted		
the use of the restraint or		
seclusion.		

Tag	Plan of Correction	Completion Date
A188 There must be documentation in the patient's medical record of the following: The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.	Please refer to tag A115.	
A431 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.	The Director of Health Information Management is responsible for implementation of the corrective action plan for tags A431, A449, and A450 except for when there is a reference to another tag or another responsible person is identified. The HIM Director developed a policy entitled "Quality Health Record Review Plan". Attachment C. This policy establishes the Director of Health Information Management (HIM) as responsible for the development and oversight of the quality health record plan. HIM coordinates the health record review process for the medical staff. For other clinicians who contribute to the medical record, it is the responsibility of the clinical department manager to identify documentation requirements within the scope of practice for the department, train staff, implement documentation standards, monitor documentation standards, and implement performance improvement plans to correct documentation deficiencies. Audit tools and results are entered into a web-based system so that reports can be pulled centrally. This assures that the HIM Director has access to all data regarding the quality and completeness of the health record. Health record quality data, analyses, performance improvement plans, and progress toward improvement (for the medical staff and other clinical departments) will be reported through the HIM Director to the appropriate organization-wide quality committee(s) for review and accountability on a semi-annual basis.	7/13/12
A449 The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to	The deficiencies cited under this tag relate to documentation in the health record of progress and response to services in three areas: discharge planning, restraint, and the plan of care. Please see tag A799 for a detailed explanation of the actions taken to come into compliance with the discharge planning standards. As described in tag A799, an ongoing auditing process to evaluate discharge planning documentation has been developed. The results of the discharge planning audits will be provided quarterly to the HIM Director for inclusion in the process for overall evaluation of the	7/13/12

Tag	Plan of Correction	Completion
1 1	1. 1 1 1 1 4 4421	Date
medications and services.	medical record as described in tag A431.	
	Please see tag A115 for a detailed explanation of the actions taken to come into compliance with the restraint standards. As described in tag A115, an ongoing auditing process to evaluate use and documentation of restraints has been developed. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115.	
	The plan of correction for documentation of the plan of care is described below under this tag (A449).	
	Plan of Care: The Chief Nursing Officer is responsible for the implementation of the corrective action plan regarding the nursing plan of care.	
	Saint Alphonsus Regional Medical Center (SARMC), a member of the Trinity Health System, uses a computerized documentation system called Powerchart. Powerchart is a Cerner product that is used by 35 of the 40+ hospitals in the Trinity Health System. Powerchart, along with most computerized documentation systems, utilizes care plan templates for specific diagnoses, conditions, or needs. The templates are built to include a list of potential interventions from which the care provider can choose, as appropriate to the patient's needs. In Powerchart, these templates are called Interdisciplinary Plans of Care (IPOC). Changes to the structure and functioning of Powerchart can only be made at the Health System level, as the changes affect all hospitals in the system. SARMC's mid-range plan is to work with Health System leaders to recommend structural and functional changes to Powerchart in order to create a care planning system that better facilitates individualization of the plan to the patient's needs and more clearly documents the patient's progress toward goals.	
	In the short term, the plan of correction is focusing on training of the nursing staff and other disciplines who contribute to the plan of care, to improve the use of the existing IPOCs and ongoing monitoring of the plan of care documentation. Please see Attachment D. More than 500 staff members are required to attend a one hour class in the computer training labs. The class includes didactic training as well as hands-on use of the computer to practice documentation of the IPOC on test patients. The content of the training includes: the importance and purpose of IPOCs; examples of appropriate/inadequate IPOCs; initiating, individualizing, updating, and discontinuing IPOCs; and using the Hand-off Form as an adjunct to the IPOC. The training also included information specific to care planning when a patient is in restraints. The training started 6/5/12 and will be completed by 6/22/12.	

Tag	Plan of Correction	Completion Date
	To reinforce the training and monitor progress, an audit tool was developed. Please see Attachment E. During the class the audit tool was provided to each participant. The expectation was communicated that each participant was to perform one audit by 7/13/12. Subsequently, auditing of IPOCs will continue on a quarterly basis. The results of the IPOC audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115.	
A450 All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.	The deficiencies cited under this tag relate to the completeness of documentation in the health record in three areas: discharge planning, restraint, and the plan of care. Please see tag A799 for a detailed explanation of the actions taken to come into compliance with the discharge planning standards. As described in tag A799, an ongoing auditing process to evaluate discharge planning documentation has been developed. The results of the discharge planning audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A431. Please see tag A115 for a detailed explanation of the actions taken to come into compliance with the restraint standards. As described in tag A115, an ongoing auditing process to evaluate use and documentation of restraints has been developed. The results of the restraint audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A115. Please see tag A449 for a detailed explanation of the actions taken to improve documentation of the plan of care. As described in tag A449, an ongoing auditing process to evaluate the documentation of	7/13/12
	the plan of care has been implemented. The results of the plan of care audits will be provided regularly to the HIM Director for inclusion in the process for overall evaluation of the medical record as described in tag A449.	
A799 The hospital must have in effect a discharge planning process that	The Director of Clinical Resource Management and Acute Social Work developed and implemented the plan of correction related to all tags cited under the Discharge Planning Condition of Participation. The Director led a team of Clinical Resource Managers (CRM) and Social Workers (MSW) in developing a written document that delineates discharge planning documentation standards for CRMs.	7/13/12
applies to all patients. The hospital's policies and procedures must be	developing a written document that delineates discharge planning documentation standards for CRMs and MSWs. The documentation standards were completed on 5/10/12. Please see Attachment F. The documentation standards define the expectations for data collection and documentation in four areas:	

Tag	Plan of Correction	Completion Date
specified in writing.	(1) Initial assessment and plan (A806 and A817), (2) Reassessment/re-evaluation (A821), (3) Implementation/ Coordination of Care (A817), and (4) Final discharge plan (A817).	Bute
	Initial Assessment and plan: The documentation standards delineate the information to be collected during the initial assessment (A806) which will be used to create the initial discharge plan (A817). The initial assessment will include, at a minimum: age; diagnosis and circumstances that brought the patient to the hospital; living situation (A809); employment; insurance/financial situation; specific patient needs based upon patient's behaviors and physical/cognitive ability to care for self (A809); and family/other support such as degree of involvement and ability to care for patient (A809). The initial discharge plan will include the likely post-discharge needs and the rationale (A808 and A817).	
	Reassessment and re-evaluation (A821): The documentation standards outline the information to be collected, analyzed, and documented to update the discharge plan. This information includes: changes in patient condition including responses to treatment and/or barriers to discharge (A809); patient behaviors and progress/response to treatment as documented by other team members such as dietitian, therapies, etc.; discussions during interdisciplinary rounds; and information discussed with patient/family (A809).	
	Implementation/Coordination of Care (A817): The documentation standards describe the information to be included in the working discharge plan including: services and referrals that have been set up (contacts, phone numbers, time frames, and why service is needed) (A808); family involvement; insurance coverage/benefits, if applicable; and documentation of patient choice.	
	Final Discharge Plan (A817): The documentation standards outline the information that will be included in the final discharge plan including: discharge location, caregivers and their ability to provide care, and the patient's ability for self-care (A809).	
	The Director of Clinical Resource Management and Acute Social Work provided education to the CRM and MSW staff members on the documentation standards on 5/16/12.	
	A team of CRM and MSW staff members led by the Director developed an audit tool to be used to monitor compliance with the documentation standards. Please see Attachment G. The audit tool addresses each item in the documentation standards. Each CRM and MSW staff member will complete 2 audits per week (a total of about 30 audits/week) through July 2012. The data from the	

Tag	Plan of Correction	Completion
		Date
	audits will be summarized, analyzed and feedback will be provided to staff members. The audit results	
	will be sent to the Director of Health Information Management to be included in the process for overall	
	evaluation of the medical record. The audits were implemented on 5/28/12.	
	The Director revised the Discharge Planning policy on 5/25/12 to describe the ongoing discharge	
	planning quality monitoring process. Auditing will be conducted on a quarterly basis.	
A806 The hospital must	Please refer to tag A799.	
provide a discharge		
planning evaluation to the		
patients identified in		
paragraph (a) of this		
section, and to other		
patients upon the patient's		
request, the request of a		
person acting on the		
patient's behalf, or the		
request of the physician.		
A808 The discharge	Please refer to tag A799.	
planning evaluation must		
include an evaluation of		
the likelihood of a patient		
needing post-hospital		
services and of the		
availability of the services.		

Tag	Plan of Correction	Completion
		Date
A809 The discharge	Please refer to tag A799.	
planning evaluation must		
include an evaluation of		
the likelihood of a		
patient's capacity for self-		
care or of the possibility		
of the patient being cared		
for in the environment		
from which he or she		
entered the hospital.		
A817 Discharge Plan	Please refer to tag A799.	
A821 The hospital must	Please refer to tag A799.	
reassess the patient's		
discharge plan if there are		
factors that may affect		
continuing care needs or		
the appropriateness of the		
discharge plan.		

Patients in Restraint: Does your Documentation "Tell the Story?"

SARMC Spring 2012 (updated 6/5/2012)



Questions about Restraint Use or Documentation?

- □ Contact Cara Nissen (caraniss@sarmc.org)
- Ask your charge nurse or manager
- □ Call 5448 (documentation questions)
- Call the Clinical Coordinator (restraint use questions)

Non-Violent vs. Violent Restraint

- □ Non-Violent Restraint
 - Used for acute medical or surgical care which supports the physical health and safety of the patient.
- Violent Restraint
 - Restraints used to manage behavior that jeopardizes the immediate safety of the patient, staff or others, regardless of the type of restraints used.
 - If the patient is attempting to harm themselves, staff, visitors, or other patients, it is considered a Violent Restraint!

Non-Violent vs. Violent Restraint

- Non-Violent Restraint should always have:
 - Non-Violent Order
 - Non-Violent forms
- Violent Restraint should always have
 - Violent Order
 - Violent forms

Charts that are reviewed often have Violent forms filled out when a Non-Violent order is placed (or vice versa). Make sure the forms and order types match.

Chemical Restraint



- Definition: The use of a medication to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- Chemical Restraint is NOT permitted or used at SARMC.
- A PRN or one-time medication prescribed to control a behavior resulting from a condition is not considered Chemical Restraint if the standard dosage is used for that condition (i.e. haloperidol used for acute psychosis).

Patient Safety and Rights

While the use of restraint to keep a patient safe is sometimes necessary, this decision should <u>never be taken lightly</u>, and the use of restraint should be <u>documented</u> carefully.

Patient Safety and Rights

- Restraints may only be imposed to ensure the <u>immediate</u> physical safety of a patient or other person.
- The decision to use restraint is <u>not driven by</u> <u>diagnosis</u>, but by a comprehensive, individualized patient assessment.
- When a patient is in restraint, the nurse should <u>continuously</u> be evaluating the situation to determine if restraints can be safely discontinued.

Restraint Orders

- Restraints may not be used on a PRN basis, except in special circumstances (see policy).
- Each restraint order should correspond with a specific incident of applying restraint.
- If the LIP orders restraints that are not utilized, another order is required if restraints are needed later in the day.
- If you discontinue restraints and then need to reapply them, a new order is needed!

Surveyors recently found restraints discontinued and then restarted without a new order.

Non-Violent Restraint Orders



- Restraint Orders must be obtained either prior to restraint placement or as soon as possible thereafter.
 - If you delay obtaining a new order for any reason (i.e. over an hour), document the reason in the medical record (Nursing Progress Note).
 - An initial order <u>must</u> be obtained prior to the end of your shift.

If there is a delay of several hours between restraint placement and obtaining an order, vey : will w to know why.

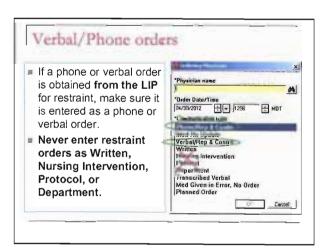
Non-Violent Restraint Orders

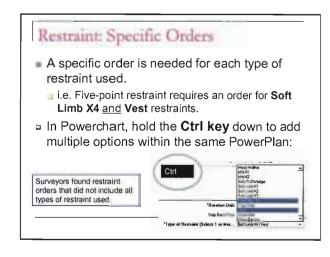
- Non-Violent Restraints must be re-ordered every calendar day a patient is continuously in restraint per policy (not every 24 hours).
- If the restraint is discontinued, you still need a new order for that calendar day.
- Remind the LIP to re-order the restraint!!!

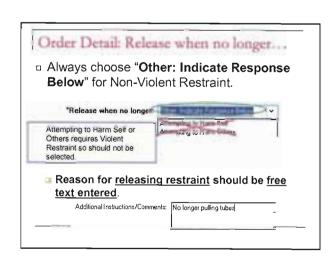
Surveyors found restraints documented without orders for every day. Many of the missing orders were on the last day the patient was in restraint.

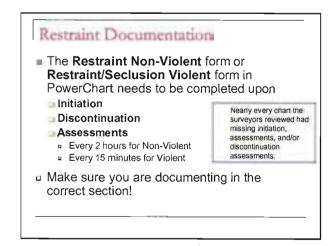
Violent Restraint Orders

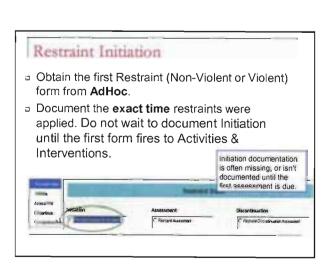
- □ Violent Restraint orders must be obtained within one hour. A new order must be obtained every 4 hours for adults (more frequently for pediatric patients—see Restraint and Seclusion policy)
- a A restraint order must be obtained whenever a patient is restrained, even for only a minute.
- Physically holding a patient for medication administration or to prevent elopement is considered Violent Restraint!
 - Restraint Type in PowerChart is "Therapeutic Hold"

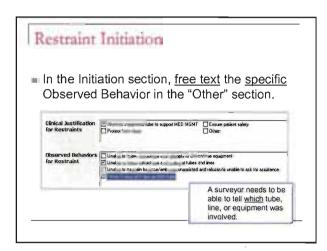


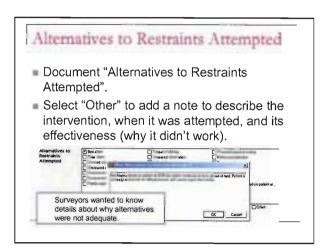


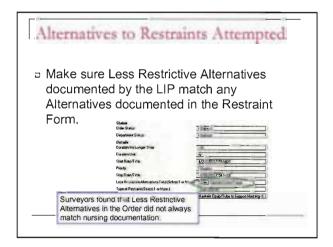


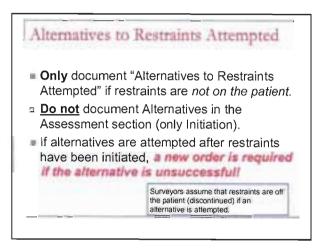


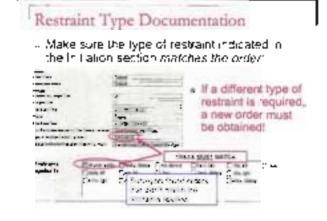


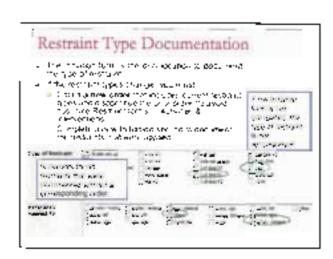


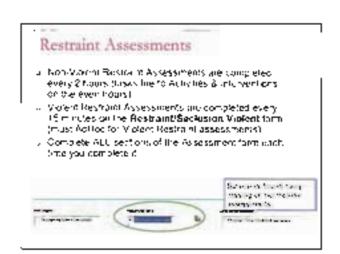


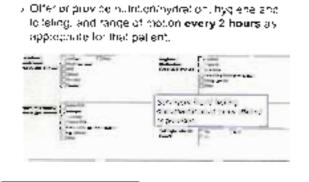




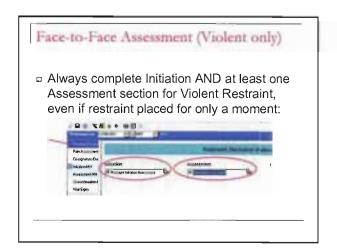


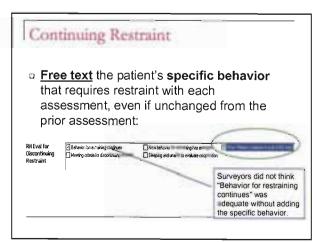


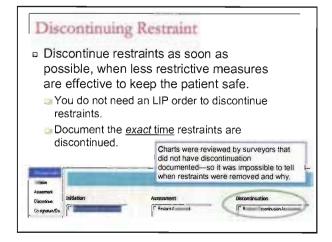


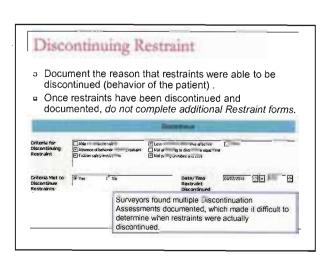


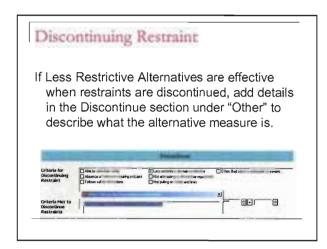
Cares for Patients in Restraint

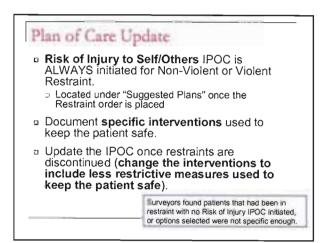


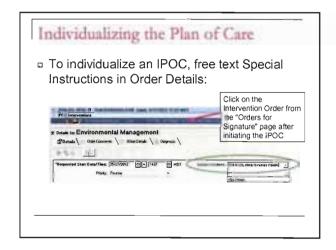


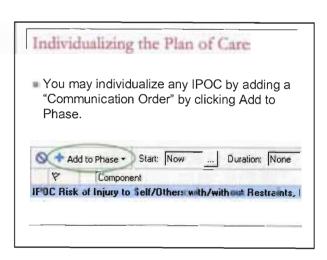












Attachment B

Date:// Staff Member	Setting:	YOUR NAME (Only if completi	ng on Paper): E	intered By:
Reason for Audit:	LEAVE "ENTERED I	BY" AND "STAFF MEMBER" FIELD:	S BLANK IF COMPLETING	ON PAPER.
The purpose of th	is Nursing Chart Aud	it Tool is to audit charts of patients ir	restraint for compliance wit	h restraint documentation.
restraint on your u restraints (refer to Review the past 3	init, you may ask you Patient Daily List or days of restraint doo	the chart of a patient that is currentler manager or charge nurse for the nation-Violent or Violent Restraint Representation, unless otherwise indicates? Contact Cara Nissen (caraniss@	ame of a patient on another ort). ted in the question.	If there is not a patient in unit that has been in
* Indicates that an	answer is required.			***************************************
		Restraint Audit 2012 (Ju	ne and July)	
Information			Answer	Comments
1.Are you completin 1) Your name 2) Setting (unit) the (if completing audit	patient is on	f so, did you clearly write:	Yes No NA	
2.* Is your unit/depa	rtment the same as the	unit that the patient is/was on?		YOUR UNIT
Enter the setting that		under Setting. If the patient was on more	Yes No	
3.What is the patien	t's FIN#?		Yes No NA	FIN #
	s you are auditing? umentation for Restrain nt for IPOC/Other Audit		Yes No NA	
Restraint Docu	mentation		Answer	Comments
5.* Check the first description completed?	ocumented Restraint fo	rm in Forms Review. Is the Initiation	Yes No	
	"Date/Time Restraint A	sent). Does the Restraint Non-Violent Applied" time? (If there is not an Initiation	Yes No NA	
specific behavior of	the patient led to the us	ent's chart, can you determine what se of restraint? (Check Restraint Initiation lotes, Significant Event Forms, etc.	Yes No	
8.Are all initial restra Forms Review and		n an hour of restraint initiation? (Check	Yes No NA	***************************************
restraint orderis th		etween restraint initiation and the initial otaining the order documented? eation)	Yes No NA	
10.Does the type of behavior?	Restraint order (Non-V	iolent vs. Violent) match the patient's		
supports the health	and safety of the patier		Yes No NA	
Violent restraint is used to manage behavior of a patient that jeopardizes the immediate safety of the patient, staff, or others. If the patient is trying to hurt themselves, staff, visitors, or other patients, it is considered Violent restraint.				
		ect Order Information. N, are they entered as phone or verbal	Yes No	
(should not be enter department order)	red by RN as written, pr	rotocol, nursing intervention, or		
restraint documente (This documentation	ed on the Restraint form n is found only in the Re on section completed w	e Order details the same as the types of ? estraint form Initiation section. There with the first restraint form, and whenever	Yes No NA	

13.Do Teas Restrictive Alternatives Tried" in the Orders match "Alternatives to Restrain Attemptod" in the Restrain Forms? 14. For each alternative to restraint attempted, is there documentation indicating the CECRPTION of the alternative intervention? 14. For each alternative intervention? 15. In the Restraint Forms, if there are documented "Alternatives to Restraint Orders are documented in the alternative intervention." 15. In the Restraint Forms, if there are documented "Alternatives to Restraint and a new restraint order obtained if the alternative was unsuccessful? 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 15. In the Order details for each Restraint order. 16. In the Order details for each Restraint order. 16. In the Order details for each Restraint order. 17. In the Order in Indicate Response Below" is indicated under "Release when no conger!" is there a reason free texted into the Additional instructions/Comments 16. In the Order order order order or and the Restraint Forms (up to 3 days), is there a detailed to the Order order order or and the Restraint Forms (up to 3 days), is there a order ord		
WHEN the measure was attempted. WHY the measure didn't work, and a detailed DESCRIPTION of the attempted intervention? 15. In the Restraint Forms, if there are documented 'Alternatives to Restraint Attempted' in any Assessment sections after restraints have been initiated, is there a new restraint order obtained if the attempted was unsuccessful? 16. In the Cried restraint order obtained if the attempted was unsuccessful? 17. If 'Other: Indicate Response Below?' 17. If 'Other: Indicate Response Below' is indicated under 'Release when no longer,' is there a resoon five texted into the Additional Instructions/Comments section? 17. If 'Other: Indicate Response Below' is indicated under 'Release when no longer,' is there a resoon five texted into the Additional Instructions/Comments section? 17. If Other: Indicate Response Below' is indicated under 'Release when no longer,' is there a resoon five texted into the Additional Instructions/Comments section? 17. If Other: Indicate Restraint orders and the Restraint Forms (up to 3 days). Is there a restraint order in place for every day the petitent is in restraint, Indiuding the last day (if applicately)? 18. In there are assessment documented every 2 hours the petitent was in restraint? 19. It have an assessment documented every 2 hours the petitent was in restraint? 19. It have an assessment documented every 2 hours the petitent was in restraint? 19. It have an assessment documented every 2 hours the petitent was in restraint? 19. It have an assessment do not discontinuation assessments. If there is not a service of the service o		Yes No NA
Altemplace" in any Assessment sections after restraints have been initiated, is there are new restraint order obtained if the alternative was unsuccessful? 16.* In the Order details for each Restraint order. Does the "Release when no longer "field show: "Other: Indicate Response Below" is indicated under "Release when no longer," is there a reason free texted into the Additional Instructions/Comments section? 17. If "Other: Indicate Response Below" is indicated under "Release when no longer," is there a reason free texted into the Additional Instructions/Comments section? 18.* Review the Restraint Orders and the Restraint Forms (up to 3 days), is there a restraint order in place for every day the patient is in restraint, including the last day (if applicable)? There should be an order for each day Restraint Forms are completed in Forms Review) There should be an order for each day Restraint Forms are completed in Forms Reviews (if applicable)? If there are again, check for discontinuation assessments. If there is not a discontinuation assessment should be counted as missed assessments. 20. Is each Restraint Assessment section completely filled out every 2 hours, the formation and Row Footing of the state of the	WHEN the measure was attempted, WHY the measure didn't work, and a detailed	Yes No NA
Does the "Release when no longer" field show: "Other: Indicate Response Below" is indicated under "Release when no longer," is there a reason free texted into the Additional Instructions/Comments section? If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated, choose NA. If "Attempting to Harm Sell" of "Attempting to Harm Others" is indicated and yes No. If there are agas, better for each day Restraint Forms are completed in Forms Review. Of Results Review for this information, hygiene/Elimination, and ROMPositioning? Check Individual Restraint Non-Vicient forms in Forms Review. Or Results Review for this information, Hygiene/Elimination, and ROMPositioning? Clock Individual Restraint Non-Vicient forms in Forms Review. Or Results Review for this information, Hygiene/Elimination, and ROMPositioning? Clock Individual Restraint for Molern Review. Or Results Review for continuing restraint, is there clear documentation elsewhere indicating the patient's (check Handoff forms, Nursing Progress Noles, Psychosocial Assessment in I/view, etc. If Restraint Assessments to not indicate the patient's specific behavior for continuing restraint, is there of a documentation elsewhere indicating the patient's Check Handoff forms, Nursing Progress Noles, Psychosocial Assessment in I/view, etc. If documentation should indicate	Attempted" in any Assessment sections after restraints have been initiated, is there	Yes No NA
If "Altempling to Harm Self" of "Attempling to Harm Others' is indicated, choose NA.	Does the "Release when no longer" field show:	Yes No
16.* Review the Restraint Orders and the Restraint Forms (up to 3 days), is there a restraint order in place for every day the patient is in restraint, including the last day (if applicable)? There should be an order for each day Restraint Forms are completed in Forms Review) 19. 1s there an assessment documented every 2 hours the patient was in restraint? If there are gaps, check for discontinuation assessments. If there is not a discontinuation assessment, gaps should be counted as missed assessments. 20. Is each Restraint Assessment section completely filled out every 2 hours, including Nutrition/hydration, Hygiene/Elimination, and ROM/Position'ng? 21. Check the "Nn Eval for Discontinuing Restraint" field in the Restraint Assessment section. 21. Check the "Nn Eval for Discontinuing Restraint" field in the Restraint Assessment section. 22. If Restraint Assessments do not indicate the patient's specific behavior for continuing restraint, is there clear documentation elsewhere indicating the patient's specific behavior that required the use of restraint? (Should be free locked under "Other") 22. If Restraint Assessments do not indicate the patient's specific behavior for continuing restraint, is there clear documentation elsewhere indicating the patient's specific behavior that required the use of restraint? (Check Handoff forms, Nursing Progress Notes, Psychosocial Assessment in In View, Patient of the specific behavior that required the use of restraint? (Check Handoff forms, Nursing Progress Notes, Psychosocial Assessment in In View, Interestraint, in the patient of the specific behavior of that courses notes with the first Restraint forms in Forms Review, is there an order 1that corresponds with the first Restraint form completed difference analysis if restraint form are present every 2 hours until 1200then there is a gap until 2000is there an order at 2000?) If there is not a Restraint form documented every 2 hours, it indicates that restraints were discontinuously. If restraints begin aga	longer:" is there a reason free texted into the Additional Instructions/Comments	Yes No NA
restraint order in place for every day the patient is in restraint, including the last day (if applicable)? (There should be an order for each day Restraint Forms are completed in Forms Review) 19.* Is there an assessment documented every 2 hours the patient was in restraint? If there are apps, check for discontinuation assessments. 20. is each Restraint Assessment section completely filled out every 2 hours. Including Nutrition/Hydration, Hygienel Elimination, and ROM/Positioning? (Check individual Restraint Nor-Violent forms in Forms Review, or Results Review for this information) 21. Check the "RN Eval for Discontinuing Restraint" field in the Restraint Assessment section. 13. It has been been been described by the section of the section of the section. 14. It has been a continuing restraint, is there clear documentation elsewhere indicating the patient's specific behavior that required the use of restraint? 25. If Restraint Assessments do not indicate the patient's specific behavior for continuing restraint, is there clear documentation elsewhere indicating the patient's specific behavior for forms, Nursing Progress Notes, Psychosocial Assessment in Iview, etc. 25. If there is a gap of longer than 2 hours in completed Restraint forms in Forms Review, is there an order that corresponds with the first Restraint form ompleted after any gap? (For example, if restraint form documented every 2 hours until 1200then there is a gap until 2000s there an order that corresponds with the first Restraint form ompleted after any gap? (For example, if restraint form documented every 2 hours, it indicates that restraints were and on the patient (discontinued). If restraints begin again, there should be a new order. 24. If there is a gap of longer than 2 hours in completed Restraint forms, is there an indication the example of the patient of the patient is not currently in restraint, or if there are gaps in the 2 hour assessments in Forms Review, is there a Discontinuation section completed indicating the exa	If "Attempting to Harm Self" of "Attempting to Harm Others" is indicated, choose NA.	
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Administrative

06/15/2012

Title: Quality Health Record Review Plan

Policy Statement:

Saint Alphonsus Regional Medical Center, including Saint Alphonsus Medical Group, reviews the patient health record for accuracy, timeliness, completeness and legibility.

Procedure:

- I. The Director of Health Information Management is responsible for the development and oversight of the medical center's Quality Health Record Review plan. The plan is designed to ensure that the record contains information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.
- II. The Health Information Management Department analyzes charts for the presence of provider and clinician documentation necessary for a complete medical record.
- III. Each clinical department responsible providing care and services will be responsible to:
 - A. Identify documentation requirements within their scope of service, train staff and implement departmental documentation standards.
 - B. Monitor staff compliance with documentation standards through regular health record audits.
 - C. When necessary, implement performance improvement plans to correct any documentation deficiencies identified through monitoring or audit activities.
- IV. V Survey is the recommended audit tool for all health record review activity for consistency in tracking and reporting.
 - A. If V-survey is not used, the department manager is responsible to report audit results to Director of HIM.
 - B. The Accreditation Specialist provides V-Survey support by setting up the audit tools, creating, running and distributing reports.
- V. Health Record Review activity for medical staff will be coordinated by HIM and reported to the QHR Documentation Team of the medical staff for review and recommendations for action.
- VI. Clinical Informatics Department provides training support for documentation process in the electronic health record.
- **VII.** Health Record Review activity for departments of the medical center will be reported to the Boise UCO Ministry Team by HIM Director semi-annually, as established by the Committee.

Related Policies: Health Record Form and Content

CMS Survey Follow Up



5 Charts Later

Why this is so important

- ► The chart is the true record of the patient's care
- ► If your documentation is not clearly spelled out in the chart, nobody can see the care you provided.
- Think back 6 months ago...
 - Think of the care you provided to 3 different patients
 What did you do? What did they do? How did you communicate to others that any of this occurred?
- This is what a surveyor does...

The Story of the IPOCs

- ► A patient did not have updated IPOCs with documentation for 4 straight days.
- ► A patient did not have any interventions selected in the IPOC.
- "Anxiety Counseling" selected as an IPOC intervention, but the staff were not able to explain what this meant.

Tell the Story: IPOCs

- A nursing care plan is based on assessing the patient's nursing care needs and developing appropriate nursing interventions in response to those needs. The nursing care plan is kept current with updates according to ongoing assessments of the patient's needs, and response to interventions.
- IPOC Goals: Have an outlined and documented plan for how to achieve a patient's goals and the patient's progress in achieving these goals.
- ★ Individualized and meaningful for each patient.
- The most important issues for a patient represented.

IPOC Documentation Expectations

- ▶ Initiated by the admitting nurse
 - Data in your IPOCs only flows from your charting after the IPOC has been opened
- ► Meaningfully updated at least every 12 hour shift, based on patient assessment and progress

The Story of the Missing Communication

- A patient who required the staff speak slowly to avoid over stimulation, did not have this written anywhere the chart.
- Instead, the staff had verbally communicated this with each other.
- ► When an handoff form was completed, it often was not signed by the oncoming nurse for 6-8 hours.
- Patients transferred to other unit with no documentation about time of transfer.

 There was no one place to consistently find a summary of
- events for a patient.
- ▶ This is how we should use the Hand Off form

Document in the Handoff Form

- ► In the anticipated events section of the Handoff Form, nursing should document an **end of shift summary.**
- An end of shift summary is a brief summary of the most important information to communicate to the next shift.
 - Important events of your shift.
- Tips and tricks for this patient's care.

 Expected (anticipated) events for the next shift
- The handoff form pulls forward this information from shift to shift for easy review.
- Review with oncoming nurse during shift to shift bedside handoff

Example Important Events

- Fall
- ► Blood product
- ▶ Procedures
- ▶ MRT/Code
- ► Isolation Precautions
- Interpreter/
 Interpreter line (blue phone) use and schedule
- ► Remote Telemetry
- ► Restraints
- ► Self harm behavior
- ► Increased oxygen demands
- ► Drip titration
- ► Critical results
- ► Unique events specific to your care area

Examples of Tips & Tricks

- ► Always speak slowly to this patient to reduce the likelihood of aggressive behavior.
- ▶ Keep Coban wrapped around the IV to prevent it from being pulled out.
- Watch foley, it will need to be emptied frequently.

Examples of Expected Events

- ► Labs; include serial labs
 - Every 6hr Troponins or every 4hr H&Hs
 - Peaks and Troughs for Vancomycin
- ▶ Planned
 - Procedure
 - Imaging studies
 - Family conference
- Transport dates for psychiatrically committed patients
- Future administrations like blood products or chemotherapy

The Story of Missing Standard Documentation

- ▶ Diabetic patient with no meals documented for 3 days
- ▶ No oral care or hygiene documented on patients
- No activities/range of motion/oral care or elimination needs documented for a patient in restraints all day
- A patient's ambulation not documented on for multiple days
- Incontinent patient with no peri-care documented
- ▶ Bed rest patient with no repositioning documented
- Patients discharged with no documentation about time of discharge or where the patient went.

Standard Documentation

Performed or observed interventions need to be documented

- ► Meals/snacks/intake
 - At least 3 times a day
 - · If patient doesn't eat, document refused If patient NPO, document under meal type at least once a shift
- Oral care twice daily,
- Oral care on the unconscious, debilitated or intubated patient at a minimum every four hours, if not more frequently.

 Daily bath/shower/cares
- Daily bath/shower/cares
 Peri-care with episodes of incontinence

Ambulation

Hygiene

- Anytime a patient gets out of bed
 Including walking in hall, going to bathroom/commode, sitting in a chair ► Turning
- Every 2 hours; document a change in patient's position Positioned on right side, left side, or supine.

Adhoc Forms

Certain events require the completion of an adhoc form.

- ► Complete ALL fields within these forms (unless not applicable).
 - More than just the yellow required fields
 - Fully describe the event in various fields of the form
- ▶ Add details in your description to tell the story of the

Examples of Adhoc Forms:

- Discharge/Depart Form
- ► Post Fall Assessment Form
- Critical Result/Test/Other Notify Form
- ► Expiration Note Form

The Story of Restraints

- ► A patient was put in restraints without an order for 5 hours.
- A restrained patient was documented in iView as being alert, oriented x4, and appropriate for multiple shifts and days.

Restraints

- ► Have you completed the restraint documentation in e-learning?
- ►It was assigned and due by June 15th.
- The e-learning takes approximately 30 minutes.

Alternatives to Restraint Attempted

- ONLY document Alternative (less restrictive) measures for restraints prior to restraint initiation.
 - Explain the specific measure attempted, when it was attempted, and why it didn't work.
 - Add a comment to provide detail instead of relying on the pick list.
- ► If an Alternative measure is attempted after a patient has been in restraint, and it is unsuccessful, a new restraint order is needed!
 - Alternative measures to restraints are interventions attempted instead of restraints
- Make sure the "Less Restrictive Alternatives tried" in the restraint Order match the "Alternatives to Restraint Attempted" in the Restraint Forms.
 - A new initiation section is needed with matching alternatives

Audit Expectation

- Purpose of audits:
 Learn by reviewing another chart as a surveyor would
 Gather data on documentation compliance
 2 audit tools must be completed by Friday, July 13th
 Restraint Audit (not including FMC and BHU)
 IPOC/Other Audit
 Audits will replace the Nursing Chart Audit tool in June and July
 Completion of Audits
 Paper copies to take with you today (complete and fax)

 V-Survey Link will be emailed to you by your manager

- Restraint Audit (not including FMC and BHU)

 Mist ai/dit at least one patient in restraints

 Audit most recent 3 days

 If your don't have a restrained patient on your unit, you should audit a patient on a different unit

 Act your charge nurse to review the Oaily Report (has list of the patients in restraints throughout the entire hospital)

► IROC/Other Audit • Audit a chart of a patient you are familiar with

Think of your last shift...

- ► Think of one patient you cared for in your last shift.
- ► Assume your practice patient is that patient.
 - You will document in M2Train



Attachment E

Date:/_/ Staff Member	Setting:	_ YOUR NAME (Only if Completin	ng on Paper):	Entered By:
	+· I FAVE "FNTERED RY"	AND "STAFF MEMBER" FIELDS	RI ANK IE COMPLETING	2 ON PADED
		ompliance with IPOC Documentati		ONTAPEN.
	***************************************	chart of a patient on your unit tha	······	
		se communicate the gaps to the r		
			,	
Fax paper audits	s to Diane Johnson (8181).	Questions? Contact Cara Nissen	(caraniss@sarmc.org)	
* Indicates that a	an answer is required.			
	·	C/Other Audit 2012 (Ju	ne and July)	
Information		· · · · · · · · · · · · · · · · · · ·	Answer	Comments
	ing this audit on paper? If so,	did you clearly write:		
1) Your name 2) Setting (unit) the (if completing audi	e patient is on it online, indicate NA)		Yes No NA	
	partment the same as the unit It unit in this comment box (inc			YOUR UNIT
	•	·	Yes No	
	nat the patient is/was on undeer the last unit the patient was	r Setting. If the patient was on more on.		
3.What is the patie	ent's FIN#?		Yes No NA	FIN#
4.What are the dat	tes you are auditing? cumentation for Restraint aud	it and	Yes No NA	annan fanoan ann an an an an ann an ann ann ann
Admission to pres	ent for IPOC/Other Audit)	1. Carro	TCS NO NA	
IPOC			Answer	Comments
5.* Review the IPC initiated?	DCs present on the patient's c	hart. Are there at least 2 subphases	Yes No	
(will be bolded)			CONSTRUCTION	***
6.Are the selected issues for that pati		tient, and cover the most important	Yes No NA	
7.Have all IPOCs	for resolved or irrelevant issue	es been discontinued?	Yes No NA	
	ubphase to view the details. An	re all of the Outcomes (bullseye icon) atient?	Yes No NA	
(graph icon)			***************************************	15315
9.Click on each su	ubphaseare interventions se	lected for each IPOC subphase?	Yes No NA	
10.Are all of the in	iterventions pertinent to the pa	atient's care at this time?	Yes No NA	
11.Is there at leas	t one IPOC subphase that inc	ludes individualized interventions?	Yes No NA	
(Comments or Co	mmunication Orders added)	uuraattootooonaanuuu aanoonaanaanaanaanaanaanaanaanaanaanaana		
12.Click on "Sugg been initiated?	ested Plans" in the Orders Me	enu. Have all IPOC Suggested Plans	Yes No NA	
(i.e. Falls, Risk of	······································			
13.Go to the Docuevery shift?	ıment in Plan tab. Has the Ou	tcome status been documented	Yes No NA	Variable 100 and 100 a
	s next to Outcomes (bullseye			
14.Has an outcom or green checkma		t half of the Outcome Scores (red X	Yes No NA	VOCAMINA COMPANIA DE LA COMPANIA DEL COMPANIA DE LA COMPANIA DEL COMPANIA DE LA C
(Click on each see	ore or look for triangle icons)		No.	

15.Have all indicators with Retrieval Icons been scored?	Yes No NA	
(When you click on icon, it allows selection of "within reference range" or "not within reference range." There will be a red X or a green checkmark if the indicator was scored.		
Other Documentation Questions	Answer	Comments
16.Review the last 3 days: In Forms Review, has a Handoff Form been completed with every shift change?	Yes No NA	MISSING DATES/TIMES
(if not, indicate the missing dates/times)	700	-
17.In the last 3 days, does the "Anticipated Events" section include all important events, tips and tricks, interpreter/blue phone use, and expected events that you are aware of for the patient?	Yes No NA	IF NOT, WHAT IS MISSING?
(View the last Handoff Form completed to see all of the documentation in the top section)	Section 1997	
18. Have Handoff forms for the past 3 days been signed off by the oncoming nurse during shift changes?	Yes No NA	IF NOT, WHAT TIME WAS IT DOCUMENTED?
19.Is appropriate ambulation and/or turning documented for the patient?	Yes No NA	IF NOT, MISSING DATES/SHIFTS:
(should include turns for patients on bedrest, trips to bathroom and in hall until independent)		
20.Under Personal Care (in IView Interventions), is a bath/shower appropriate for the patient documented daily for the past 3 days?	Yes No NA	IF NOT, MISSING DATES/TIMES:
21.Are there any Pain Interventions documented in View? (i.e. positioning, ice)	Yes No NA	
(if patient does not have pain, indicate NA)		
22.* Is oral care documented according to policy?	Yes No	IF NOT, MISSING DATES/SHIFTS:
(BID or every 2-4 hours for unconscious, debilitated, or intubated patients)		
23.Review IView Interventions (past 3 days). Are all meals documented (or refused)?	Yes No NA	IF NOT, MISSING DATES/TIMES:
Advance Directives	Answer	Comments
24.Do you know where the end-of-life Resource Box is located on your unit?	Yes No NA	WHERE?
(if you are unsure, ask your manager). CST and non-applicable specialty units may mark NA)		
25.Can you list 3 items found in the End of Life box on your unit? (if applicable):	Yes No NA	ITEMS:
26.Do you know who you can call to restock the End of Life Resource Box?	Yes No NA	WHO DO YOU CALL?
27.Do you know that End of Life Resources are available for patients other than on the Palliative Care service?	Yes No NA	
20 De veu know that a "Comfact Cora" order set in DeverChart can be used for		
28.Do you know that a "Comfort Care" order set in PowerChart can be used for patients transitioning to comfort measures that addresses the most common end of life comfort needs?	Yes No NA	
patients transitioning to comfort measures that addresses the most common end of	Yes No NA Yes No NA	
patients transitioning to comfort measures that addresses the most common end of life comfort needs? 29.Check the Essential Admission Form in Forms Review. Was the patient asked if		

CRM/MSW Department Documentation Standards/Expectations

* Remember defensive charting; "if it not documented it was not done"

Initial Assessment/Plan:

- Age
- Diagnosis and circumstances that brought patient to the hospital
- Living situation
- Employment
- Insurance/financial status
- Specific patient needs based upon patient's behaviors/physical and cognitive ability to care for self
- Family support (document specifics i.e. who); degree of involvement and their ability to care for patient. (When talking to family members be sure to follow HIPAA guidelines, use quotes as appropriate)
- Initial discharge plan: likely post discharge needs and why

Reassessment/re-evaluation:

- Summarize any changes including responses to treatment and/or barriers to discharge
- Recognize consultations: Nutrition, PT/OT, etc include patient behaviors and progress/responses to treatment
- Revise discharge plan if appropriate and document why revision is made
- Rounds discussion documentation: identify rounds (i.e. Hospitalist, ICU)what was discussed and share with patient/family
- Staffing w/interdisciplinary team members: what was discussed and share with patient

Implementation/Coordination of Care:

- Services/referrals set up, contacts, phone numbers, time frames & why service needed
- Family involvement
- Insurance coverage/benefits if applicable
- Patient Choice: documentation that list provided of appropriate resources (patient choice form)

Final DC Plan:

• Document finalized DC plan including where patient is going (including specifics), in whose care and their ability to provide care, and patient's behaviors/ability to care for self either partially or completely.

Original: 5-15-12

^{*}Individuals may choose to use the headers in their case management/social work progress note and then document necessary elements

Attachment G

CRM/MSW DISCHARGE PLANNING AUDIT TOOL

FIN#		Room #			Admit	Date				Initial a	ssessment	needs ide Yes	entified?
Pt Name			Reviev	Review Date			Age Diagnosis						
CRM		Social work referral? Social Worker				Home location □ □ □ Financial/Insurance □ □							
Mark a C= CRM If NO, identify a Follow patient the patient/patient ne	reas of concern hrough out the	in Feedb	ack sec	ction							ssment a		
1. IPOC initi	ated/updated	?		Yes	No							_	
2. Is there an initial &ongoing assessment in Power Chart that identifies specific patient DC needs involvement of Pt/family? Are the following items addressed and documented in the initial assessment?			С	 Living situation Homeless Transportation Clinical Concerns Safety Concerns Lack of finance resources Family request assistance Need for Compassistance 					equesting Commu	o Support System issues o Ability to Perform ADL's unity of family to provide care			issues orm y to
				Initial Assessment		Reassessment documented		Reassessment documented		Reassessment documented		Reassessment documented	
				Da	ate	Date		Date		Date		Date	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	I assessment de fic to the pt's n		plan				<u>-</u>						
Need for DME contains details and contact info and patient choice form documented													
Need for HH or hospice contains details and contact info and patient choice form documented													
6. Discharge to another level of care contains details and contact info and patient choice form documented													
7. Final DC plan i.e. where patient is going (including specifics), in whose care & their ability to provide care, & patient's behaviors/ability to care for self either partially or completed.													
8. Coordination of Care Documentation of patient's specific DC needs assessments and/or recommendations by various disciplines: PT, OT, Speech, RT, Nrsg, CM, SW, Designate discipline(s) in comment section to the right):													
9. Are disciplinary rounds summarized; (what was discussed) plan changes, needs, including documentation that it was shared with patient													
Ordered CRM/MSW consults are completed or discontinued													
	erqual medi	cal nec	essity			$\mathbf{Y} \square \mathbf{N}$							
	review done		- 3										
T 1' ' '		1 D. 1			FEE	DBAC		C =					
Indicator #	Assessmen	t Date						Comme	IIIS				
Reviewer			Follow	-up Conta	act With CF	RM							

Rev 9/28/07sb; 10/1/07sb; 10/8/07sb; 10/15/08sb, 12/6/07sb 6-09jc 11-10pt,2-11jc, 5-12jc

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING IDDK97 05/01/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTEL BOISE, ID 83706 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) B 000 16.03.14 Initial Comments B 000 Please see enclosed The following deficiencies were cited during the plan of correction. complaint investigation survey of your hospital. The surveyors conducting the investigation were: Gary Guiles RN, HFS, Team Leader Rebecca Lara RN, BA, HFS BB283 16.03.14.360.12 Record Content BB283 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88)FACILITY STANDARDS c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending Bureau of Facility Standards

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

6899

Y55911

TITLE

CEC

If continuation sheet 1 of 3

(X6) DATE

Bureau	of Facility Standards						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/01/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ST ALPHONSUS REGIONAL MEDICAL CENTE			1055 NOR BOISE, ID	RTH CURTIS 83706	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
BB283	Continued From pa	ige 1	_	BB283			
	physician; and (10-	14-88)					
	iii. Progress notes v	written by the nursing	,				

PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
BB283	Continued From page 1	BB283		
	physician; and (10-14-88)			
	iii. Progress notes written by the nursing personnel; and (10-14-88)			
	iv. Progress notes written by allied health personnel. (10-14-88)			
	f. Reports of special examinations including but not limited to: (10-14-88)			
	i. Clinical and pathological laboratory findings; and (10-14-88)			
	ii. X-ray interpretations; and (10-14-88)			
	iii. E.K.G. interpretations. (10-14-88)			
	g. Conclusions which include the following: (10-14-88)	THE PERSON NAMED IN COLUMN TO THE PE		
	i. Final diagnosis; and (10-14-88)			
	ii. Condition on discharge; and (10-14-88)			
	iii. Clinical resume and discharge summary; and (10-14-88)			
	iv. Autopsy findings when applicable. (10-14-88)			
	h. Informed consent forms. (10-14-88)			
	i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90)			
	i. Name and affiliation of requestor; and (3-1-90)			
	ii. Name and relationship of requestee; and (3-1-90)			

Bureau of Facility Standards

Y55911

PRINTED: 06/05/2012 FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING IDDK97 05/01/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1055 NORTH CURTIS ROAD ST ALPHONSUS REGIONAL MEDICAL CENTER BOISE, ID 83706 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) BB283 **BB283** Continued From page 2 iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to federal tags A431, A449, and A450 as they relate to the failure of the facility to ensure patients' medical records 1) accurately and effectively described services provided to patients and patients' response to those services and 2) were complete. BB461 16.03.14.470.08 Discharge Planning **BB461** 08. Discharge Planning. Consideration for continued care and services in the community after discharge, placement alternatives, and utilization of community resources shall be initiated on admission and carried out to ensure that each patient has a documented plan for continuing care that meets his individual needs. Provision shall be made for exchange of appropriate information with outside resources. (10-14-88)This Rule is not met as evidenced by: Refer to federal tags A799, A806, A808, A809, A818, and A821, as they relate to the failure of the hospital to ensure patients were evaluated for discharge planning needs and a discharge plan was developed and implemented to meet those

Bureau of Facility Standards

needs.

Y55911

State Survey Plan of Correction Saint Alphonsus Regional Medical Center Complaint Survey Concluded May 1, 2012

Tag	Plan of Correction		
		Date	
BB283 Record Content	Please refer to Federal tag A431.		
Federal Tag A431			
Federal Tag A449	Please refer to Federal tag A449.		
Federal Tag A450	Please refer to Federal tag A450.		
BB461 Discharge	Please refer to Federal tag A799.		
Planning			
Federal Tag A799			
Federal Tag A806	Please refer to Federal tag A806.		
Federal Tag A808	Please refer to Federal tag A808.		
Federal Tag A809	Please refer to Federal tag A809.		
Federal Tag A818	Please refer to Federal tag A817.		
Federal Tag A821	Please refer to Federal tag A450.		





C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

June 27, 2012

Sally Jeffcoat, Administrator St Alphonsus Regional Medical Center 1055 North Curtis Road Boise, ID 83706

Provider #130007

Dear Ms. Jeffcoat:

On May 1, 2012, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005440

Allegation #1: Patients were inappropriately restrained.

Findings #1: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records, of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Five of the six medical records that were reviewed (including the record of a 74 year old male admitted on 3/12/12) contained inadequate documentation to support the use of restraints. Problems identified related to restraints included:

- 1. Comprehensive assessments indicating the need for restraints were not was performed, including documentation that less restrictive interventions had been tried and were determined to be ineffective.
- 2. The use of physical restraints was not incorporated into patients' plans of care.

Sally Jeffcoat, Administrator June 27, 2012 Page 2 of 7

- 3. Physician orders were not consistently obtained and when restraints were utilized.
- 4. Restraints were not discontinued at the earliest possible time.
- 5. The behavior which led to the use of restraints was not documented.
- 6. The symptoms that warranted the use of the restraints was not documented.
- 7. Patients' response to restraints and the rationale for their continued use was not documented.

The complaint was substantiated and deficiencies were cited at 42 CFR Part 482.13.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: Patients were not informed of their condition and other information pertinent to their care.

Findings #2: An unannounced vist was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records, of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievences were reviewed.

Five current patients were interviewed on the medical unit on 4/30/12. All five stated they were well informed about their condition and the care they received. Documentation of communication between nurses and patients or family members was incomplete, however.

One medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Physician and social service progress notes documented the patient's power of attorney (POA) was kept informed of his medical condition and discharge planning efforts.

Nursing progress notes did not document that his POA was informed of his condition, however. For example, Incident reports documented he experienced falls on 3/26/12 and 3/28/12. No documentation was present in the medical record which described the falls or stated that the POA or physician were notified of the events. Restraint forms documented the patient was restrained on 3/18/12 from 1:00 AM until 10:15 AM. No documentation was present in the medical record stating the patient's POA was informed of this event. Restraint forms documented the patient was restrained on 3/27/12 at 4:00 PM until 3/30/12 at 12:00 PM. No documentation was present in the medical record stating the patient's POA was informed of this event.

The medical records were reviewed with hospital staff through out the survey. The electronic

Sally Jeffcoat, Administrator June 27, 2012 Page 3 of 7

medical record made it difficult to tell whether the problem was with the actual communication or whether the communication was not documented because of structural problems with the record.

Since the electronic medical record impeded the documentation of communication with the patient and his/her family, deficiencies were cited at 42 CFR Part 482.24, Condition of Participation for Medical Records.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: Patients were over medicated which caused symptoms such as sleeping much of the time and interfering with their ability to walk.

Findings #3: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

None of the medical records reviewed contained documentation that indicated patients were sedated for long periods of time except for patients who were chemically restrained while on ventilators.

Patients commonly experience some short term sedation as staff titrate medications which treat the causes of behaviors. In addition, patients with behavioral problems often become exhausted from those behaviors, which can appear as over sedation. This can interfere with their ability to ambulate and to perform activities of daily living. The medical records of patients who did experience declines in their ability to perform certain tasks were provided with therapy to increase their level of independence.

All of the medical records reviewed documented that orders for sedating medications were changed in response to patients' changing condition and family requests. All of the medical records reviewed documented staff responded to patients' changing condition. Therefore, the allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Care ordered by some physicians conflicted with care by other physicians.

Findings #4: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were

Sally Jeffcoat, Administrator June 27, 2012 Page 4 of 7

reviewed.

None of the medical records reviewed contained documentation that care provided by one physician was contraindicated by another physician. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. A physician progress note, dated 3/30/12 at 3:15 PM, stated the patient was unable to void. The note stated he was catheterized when his bladder scan showed his bladder contained over 900 milliliters (approximately one quart) of urine. The patient was catheterized nine times between 4/03/12 and 4/08/12. A physician progress note, dated 4/06/12 at 12:23 PM, stated a urologist had seen the patient six weeks earlier and did not feel catheterization was warranted at that time. However, that was prior to the patient retaining large amounts of urine. The patient's urinary symptoms resolved after 4/08/12 and he had not been catheterized since.

Urinary retention in large quantities is a medical emergency. Physicians responded to the patient's needs. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were not treated for pain.

Findings #5: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

None of the medical records reviewed contained documentation that patients experienced severe pain. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Pain was measured at the hospital on a scale of 0-10. The patient's medical record contained documentation of his pain level on a daily basis. Between 4/10/12 and 4/19/12, his pain was documented as zero except for 4/12/12 and 4/19/12 when it was documented as two of ten.

The cases which were reviewed did not contain evidence that the patients experienced significant pain.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Patients with urinary tract infections were not treated in a timely manner.

Findings #6: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff

Sally Jeffcoat, Administrator June 27, 2012 Page 5 of 7

were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Only one medical record which was reviewed documented a patient with a urinary tract infection. This patient was a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. Laboratory tests initiated on 3/12/12 and on 3/28/12 showed no evidence of urinary tract infection. He developed urinary symptoms on 4/12/12 and laboratory tests at that time did confirm a urinary tract infection. He was treated with two antibiotics beginning on 4/13/12. The urinary tract infection resolved. Urinary tract infections were not noted for the other patients whose records were reviewed.

No evidence of untreated urinary tract infections was found.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The hospital did not provide adequate discharge planning services.

Findings #7: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

Three of the six medical records did not contain documentation of adequate discharge planning. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. While the record contained multiple social service notes addressing discharge planning, a discharge planning evaluation had not been completed and a formal discharge plan was not documented.

Two medical records did not document where the patient was discharged to nor did they document whose care they were discharged to. These records also did not contain documented discharge planning evaluations or discharge plans.

Hospital policies did not specify how discharge planning needs should be assessed and documented. The policies also did not state how discharge plans should be documented.

The hospital had not developed systems which provided direction to staff in order to ensure a consistent approach to discharge planning had been implemented. Federal deficiencies related to discharge planning were cited at 42 CFR Part 482.43 and state deficiencies were cited at IDAPA 16.03.14200.04.

Sally Jeffcoat, Administrator June 27, 2012 Page 6 of 7

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #8: Patients were not assisted with meals.

Findings #8: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

While assistance with meals was not documented, food intake was documented in all records reviewed. No unusual weight loss patterns were identified. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. He had diagnoses of dementia and psychoses. His admission weight was 147 pounds on 3/12/12. His documented meal intake ranged from 25% to 100%. His weight increased initially to 149 pounds on 3/17/12, which may have been due in part to water retention. His weight dipped to 143 pounds on 3/19/12 and then rose again. He weighed 153 pounds on 4/25/12, six pounds more than when he entered the hospital. This did not appear to be water retention as his ankles were not swollen upon observation.

The above patient was observed eating lunch on 4/25/12. Staff set up his tray assisting with things like opening containers. He was observed feeding himself.

Patients who were interviewed stated staff assisted them when needed including meal assistance.

No nutritional problems were identified. The allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: Patients did not receive needed tests.

Findings #9: An unannounced visit was made to the hospital on 4/24/12 through 5/01/12. Staff were interviewed. Five current patients were interviewed. Six medical records of patients who had been restrained, were reviewed. Hospital policies, incident reports, and grievances were reviewed.

All of the medical records reviewed documented laboratory, radiological, and other testing was provided as ordered. For example, one medical record documented a 74 year old male who was admitted to the hospital on 3/12/12 and was currently a patient as of 4/30/12. He received a computed tomography (CT) exam of his head on admission. He also received various laboratory tests including blood counts, blood chemistry, urine analysis, and urine cultures. All ordered tests were completed.

Sally Jeffcoat, Administrator June 27, 2012 Page 7 of 7

The patient received three visits by a neurologist, on 3/26/12, 3/31/12, and 4/14/12. All of the recommendations by the neurologist were acted upon.

Patients received laboratory, radiology, and other testing as ordered. The allegation could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/srm